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| 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 10/10/2024 |
| 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) |
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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 49199</p> <p>Based on review of documentation, interviews and review of the facility policy, the facility failed to ensure 3 residents (#456, #457 and #458) were not abused from one staff member. The deficient practice could lead residents to suffer from psychosocial harm.</p> <p>Findings include:</p> <ul style="list-style-type: none"> - Resident #456 was admitted on [DATE] with a diagnosis of displaced intertrochanteric fracture of the right femur, chronic systolic heart failure, anxiety disorder, depression, acute pain due to trauma and tachycardia. <p>Review of the Minimum Data Set (MDS) assessment, dated April 4, 2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which revealed no cognitive impairment.</p> <p>Review of the care plan dated April 4, 2024, revealed that resident #456 was dependent on staff for care. An intervention included that the staff would converse with him while providing care.</p> <p>Review of the care plan dated April 11, 2024 revealed resident #456 was resistive to care. The goal was to demonstrate effective coping skills and encouraging him to participate as much as possible in his care.</p> <p>A grievance report was completed by resident #456 on May 22, 2024. It stated that resident #456 expressed CNA (Certified Nursing Assistant/ staff #42) was not qualified for her job and staff #42 told resident #456 I am 55 and I am not picking you up.</p> <ul style="list-style-type: none"> - Resident #457 was admitted to the facility on [DATE] with a diagnosis of acute cystitis, , anxiety disorder and depression and during her stay developed a urinary tract infection. <p>Review of the MDS assessment, dated July 11, 2024, revealed a BIMS score of 13 which revealed no cognitive impairment.</p> <p>A grievance report was completed by resident #457 on July 16, 2024, involving an incident with</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.

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| 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 - Some</p> | <p>staff #42 on July 15, 2024. It stated Resident told day shift CNA that NOC (night shift) shift CNA, staff #42, got upset and was rude to patient about having to replace bed sheets after urine spilled on them from using the bed pan. Staff #42 was not assigned to resident #457 again.</p> <p>Review of the nursing progress note, dated July 16, 2024 at 12:38 PM stated that the resident #457 had some care issues the night before.</p> <p>Review of the care plan dated July 19, 2024 revealed that resident #457 was dependent on staff for care.</p> <p>- Resident #458 was admitted to the facility on [DATE] with a diagnosis of wedge compression fracture of first lumbar vertebra, enterocolitis due to clostridium difficile, urinary tract infection and orthostatic hypertension.</p> <p>Review of the MDS assessment dated , June 24, 2024 revealed a BIMS score of 14 which revealed no cognitive impairment. Further review revealed the resident required supervision or touching assistance with toileting and hygiene.</p> <p>Review of the care plan, dated June 27, 2024 revealed that resident #458 was a fall risk, had weakness, was unsteady on his feet and was dependent on staff.</p> <p>A grievance report was completed by resident #458 on July 30, 2024, involving an incident with</p> <p>staff #42. The report included resident #458 statement which stated that the CNA (staff #42) was very rude to the resident after he asked for assistance with wiping his bottom after toileting. The statement stated resident #458 struggled with wiping himself due to broken back that required him to wear a TLSO (thoracolumbar sacral orthosis) brace, which made it difficult to twist. The statement further stated, due to his orthostatic hypotension, he gets very dizzy and was scared of passing out or falling. The statement included that the CNA (staff #42) told resident #458 you're just trying to get an old black woman to wipe your ass.</p> <p>An interview was conducted on October 9, 2024 at 10:44 AM with Staff #18, Resident Relations Manager. She stated she was the person who spoke with residents #456, #457, and #458 in regard to the grievances against staff #42. These incidents were brought to the attention of the Director of Nursing (DON, staff #28). It was verified from staff #18 that staff #42 was written up on</p> <p>October 1, 2024. Review of the Corrective Action Form revealed a fourth resident had complained about staff #42 which stated staff #42 would not help because resident was independent. The form also stated that the comment lead to resident feeling uncomfortable. Further review of the Corrective Action Form revealed that staff #42 was counseled, however she refused to sign the form.</p> <p>An interview was conducted on October 9, 2024 with CNA, staff #43 who stated that abuse include resident not being covered up, not being changed and verbal abuse. Staff #43 stated it is 100% abuse when the staff member says you just want me to come in and wipe your ass? to any resident.</p> <p>An interview was conducted on October 9, 2024 at 1:06 PM with Licensed Practical Nurse (LPN,</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 - Some</p> | <p>staff #40). Staff #40 stated that it is verbal abuse when the staff member says you just want me to come in and wipe your ass? to any resident.</p> <p>An interview was conducted on October 9, 2024 at 1:11 PM with DON (staff #28). Staff #28 stated that it is a lack of customer service and poor communication and incredibly rude when the staff member says you just want me to come in and wipe your ass? to any resident. Staff #28 stated that it was abuse only if the resident said they felt uncomfortable. When staff #28 was asked if she felt these incidents should have been reported, she stated No, only if it was stated they were uncomfortable should it have been reported.</p> <p>The facility's abuse policy dated 2022, version 0622 states By definition, abuse is the 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, mental abuse including facilitated or enabled through the use of technology, and misappropriation of property.</p> | | |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50553</p> <p>Based on clinical record review, facility documentation, staff interviews, and policy review, the facility failed to ensure one resident (#96) was free from misappropriation of the resident's property. The deficient practice could result in resident rights being violated due to the misappropriation of personal property.</p> <p>Findings Include:</p> <p>Resident #96 was admitted to the facility on [DATE] with diagnoses that included peripheral vascular disease, anxiety disorder and cellulitis.</p> <p>Resident #96's inventory sheet dated December 7, 2022 revealed that the resident had 1 phone and 1 charger in her possession.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating intact cognition.</p> <p>Review of the facility's investigative report revealed that Resident #96's cell phone went missing the night of April 9, 2023 or early in the morning on April 10, 2023, and was reported to the former Director of Nursing (DON) on April 10, 2023. The report details that Resident #96's family member was alerted via email that changes had been made to the phone. The report also included that staff and residents were interviewed as a part of the ongoing investigation, and one registry-contracted Certified Nursing Assistant (CNA/Staff#71) was unable to be contacted. The report revealed that the facility attempted to contact staff #71 by text, phone call, and registry app message platform, but could not contact her because she used a false phone number. The report included that one other resident was noted to have missing property in this time period.</p> <p>Review of progress notes revealed an entry from the Interdisciplinary team (IDT) on April 19, 2023 which revealed that the IDT team met with the resident to discuss the investigation of her missing iPhone and steps to replace the item.</p> <p>On April 24, 2023, an officer from Scottsdale Police Department responded to a call and went to the facility, where he took a report from resident #96. In this report, resident #96 reported that her iPhone 11, along with a pair of tweezers and a bottle of over-the-counter pills, was stolen out of her room between midnight and 4:00AM on April 10, 2024. In this report, Resident #96 also stated she suspected that her items were taken by her CNA that night, and gave Staff #71's name and description.</p> <p>Review of the facility's complaint to the Arizona State Board of Nursing (AZBN) dated May 20, 2023 revealed that Staff #71 was reported to the AZBN by the facility, detailing the incident of the missing phone on April 9th and April 10th, 2024. The complaint also states that staff #71 was found to be in possession of the missing item, with the location of staff #71 being unknown.</p> <p>(continued on next page)</p> | | |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>An interview was conducted on October 10, 2024 at 8:28AM with a Licensed Practical Nurse (LPN/Staff #64), who stated that every item a resident comes into the facility with is tracked on the inventory sheet. She also stated that if an item were to go missing, she would attempt to find the item first, and then report it to the administrator if she could not find it. She would then help to fill out a grievance form and notify family.</p> <p>An interview was conducted on October 10, 2024 at 10:37 AM with the Executive Director (ED/Staff #21), who described the facility process for a missing item to be to search for the item thoroughly, check the inventory sheet, check the lost and found, and report the item as lost. He reported that if an item is not found, the facility will typically replace it. The ED also added that if residents bring in items after admission, these items should be added to the inventory sheet. When asked about the investigation for resident #96's missing cell phone, the ED stated that it was reported and investigated by the previous administrator. The ED brought up the report made to the AZBON, stating that he did not believe that staff #71 was found in possession of the missing item. He believed that this was written incorrectly, stating that the previous administrator was just unable to contact staff #71. The ED inquired about submitting an addendum to the 5-day report to include that the allegation could not be substantiated by the facility.</p> <p>Review of the facility's policy titled, Resident Rights/Dignity: Resident Rights, revealed that residents had the right to be free from abuse, neglect, and misappropriation of resident property.</p> | | |

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| <p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49199</p> <p>Based on review of documentation, interviews and review of the facility policy, the facility failed to ensure the policy for abuse was implemented for 3 residents (#456, #457 and #458). The deficient practice could lead residents to suffer from psychosocial harm and further abuse of more residents from staff member.</p> <p>Findings include:</p> <ul style="list-style-type: none"> - Resident #456 was admitted on [DATE] with a diagnosis of displaced intertrochanteric fracture of the right femur, chronic systolic heart failure, anxiety disorder, depression, acute pain due to trauma and tachycardia. <p>Review of the Minimum Data Set (MDS) assessment, dated April 4, 2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which revealed no cognitive impairment.</p> <p>Review of the care plan dated April 4, 2024, revealed that resident #456 was dependent on staff for care. An intervention included that the staff would converse with him while providing care.</p> <p>Review of the care plan dated April 11, 2024 revealed resident #456 was resistive to care. The goal was to demonstrate effective coping skills and encouraging him to participate as much as possible in his care.</p> <p>A grievance report was completed by resident #456 on May 22, 2024. It stated that resident #456 expressed CNA (Certified Nursing Assistant/ staff #42) was not qualified for her job and staff #42 told resident #456 I am 55 and I am not picking you up.</p> <ul style="list-style-type: none"> - Resident #457 was admitted to the facility on [DATE] with a diagnosis of acute cystitis, , anxiety disorder and depression and during her stay developed a urinary tract infection. <p>Review of the MDS assessment, dated July 11, 2024, revealed a BIMS score of 13 which revealed no cognitive impairment.</p> <p>A grievance report was completed by resident #457 on July 16, 2024, involving an incident with staff #42 on July 15, 2024. It stated Resident told day shift CNA that NOC (night shift) shift CNA, staff #42, got upset and was rude to patient about having to replace bed sheets after urine spilled on them from using the bed pan. Staff #42 was not assigned to resident #457 again.</p> <p>Review of the nursing progress note, dated July 16, 2024 at 12:38 PM stated that the resident #457 had some care issues the night before.</p> <p>Review of the care plan dated July 19, 2024 revealed that resident #457 was dependent on staff for care.</p> <p>(continued on next page)</p> | | |

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| <p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>- Resident #458 was admitted to the facility on [DATE] with a diagnosis of wedge compression fracture of first lumbar vertebra, enterocolitis due to clostridium difficile, urinary tract infection and orthostatic hypertension.</p> <p>Review of the MDS assessment dated , June 24, 2024 revealed a BIMS score of 14 which revealed no cognitive impairment. Further review revealed the resident required supervision or touching assistance with toileting and hygiene.</p> <p>Review of the care plan, dated June 27, 2024 revealed that resident #458 was a fall risk, had weakness, was unsteady on his feet and was dependent on staff.</p> <p>A grievance report was completed by resident #458 on July 30, 2024, involving an incident with staff #42. The report included resident #458 statement which stated that the CNA (staff #42) was very rude to the resident after he asked for assistance with wiping his bottom after toileting. The statement stated resident #458 struggled with wiping himself due to broken back that required him to wear a TLSO (thoracolumbar sacral orthosis) brace, which made it difficult to twist. The statement further stated, due to his orthostatic hypotension, he gets very dizzy and was scared of passing out or falling. The statement included that the CNA (staff #42) told resident #458 you're just trying to get an old black woman to wipe your ass. The report stated resident #458 did not want staff #42.</p> <p>An interview was conducted on October 9, 2024 at 10:44 AM with Staff #18, Resident Relations Manager. She stated she was the person who spoke with residents #456, #457, and #458 in regard to the grievances against staff #42. These incidents were brought to the attention of the Director of Nursing (DON, staff #28). It was verified from staff #18 that staff #42 was written up on</p> <p>October 1, 2024. Review of the Corrective Action Form revealed a fourth resident had complained about staff #42 which stated staff #42 would not help because resident was independent. The form also stated that the comment lead to resident feeling uncomfortable. Further review of the Corrective Action Form revealed that staff #42 was counseled, however she refused to sign the form.</p> <p>Review of the facility documentation revealed that the incident with staff #42 were not reported nor thoroughly investigated.</p> <p>An interview was conducted on October 9, 2024 with CNA, staff #43 who stated that abuse include resident not being covered up, not being changed and verbal abuse. Staff #43 stated it is 100% abuse when the staff member says you just want me to come in and wipe your ass? to any resident.</p> <p>An interview was conducted on October 9, 2024 at 1:06 PM with Licensed Practical Nurse (LPN, staff #40). Staff #40 stated that it is verbal abuse when the staff member says you just want me to come in and wipe your ass? to any resident.</p> <p>An interview was conducted on October 9, 2024 at 1:11 PM with DON (staff #28). Staff #28 stated that it is a lack of customer service and poor communication and incredibly rude when the staff member says you just want me to come in and wipe your ass? to any resident. Staff #28 stated that it was abuse only if the resident said they felt uncomfortable. When staff #28 was asked if she felt these incidents should have been reported, she stated No, only if it was stated they were uncomfortable should it have been reported.</p> <p>(continued on next page)</p> | | |

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| <p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>The facility's policy on abuse dated 2022, version 0622 states If abuse is witnessed or suspected, reporting and investigation will take place in this manner:</p> <ol style="list-style-type: none"> 1. Executive Director (ED) will be notified. 2. ED and witness who is reporting will notify the following entities: <ol style="list-style-type: none"> A. Adult Protective Services B. Ombudsman C. State Survey Agency D. Law enforcement when applicable E. Facility Director of Nursing (DON) 3. DON will notify the following: <ol style="list-style-type: none"> A. Physician B. Responsible le Party C. VP of Clinical Operations 4. ED will begin investigation immediately and complete within 5 working days using the Abuse Investigation Packet. A minimum of three residents will be interviewed in order to determine if there is a trend. Interviews may also include the Alleged Perpetrator, Witnesses and Staff Members as applicable. 5. Suspected abuse will be reported in accordance with timeframe's and standards required by CMS. 6. If the alleged perpetrator is an employee, they will be immediately suspended pending the results of the investigation. 7. The resident suspected of being abused will be monitored and placed on alert charting. 8. When the investigation is complete, the ED will submit a summary to the entities in #2. 9. All abuse investigation information will be documented and logged according to facility protocol. | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 49199</p> <p>Based on review of documentation, interviews and review of the facility policy, the facility failed to report alleged violations of abuse for resident's (#456, #457 and #458) . The deficient practice could lead to further abuse of residents from staff member.</p> <p>Findings include:</p> <ul style="list-style-type: none"> - Resident #456 was admitted on [DATE] with a diagnosis of displaced intertrochanteric fracture of the right femur, chronic systolic heart failure, anxiety disorder, depression, acute pain due to trauma and tachycardia. <p>Review of the Minimum Data Set (MDS) assessment, dated April 4, 2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which revealed no cognitive impairment.</p> <p>Review of the care plan dated April 4, 2024, revealed that resident #456 was dependent on staff for care. An intervention included that the staff would converse with him while providing care.</p> <p>Review of the care plan dated April 11, 2024 revealed resident #456 was resistive to care. The goal was to demonstrate effective coping skills and encouraging him to participate as much as possible in his care.</p> <p>A grievance report was completed by resident #456 on May 22, 2024. It stated that resident #456 expressed CNA (Certified Nursing Assistant/ staff #42) was not qualified for her job and staff #42 told resident #456 I am 55 and I am not picking you up.</p> <ul style="list-style-type: none"> - Resident #457 was admitted to the facility on [DATE] with a diagnosis of acute cystitis, , anxiety disorder and depression and during her stay developed a urinary tract infection. <p>Review of the MDS assessment, dated July 11, 2024, revealed a BIMS score of 13 which revealed no cognitive impairment.</p> <p>A grievance report was completed by resident #457 on July 16, 2024, involving an incident with staff #42 on July 15, 2024. It stated Resident told day shift CNA that NOC (night shift) shift CNA, staff #42, got upset and was rude to patient about having to replace bed sheets after urine spilled on them from using the bed pan. Staff #42 was not assigned to resident #457 again.</p> <p>Review of the nursing progress note, dated July 16, 2024 at 12:38 PM stated that the resident #457 had some care issues the night before.</p> <p>Review of the care plan dated July 19, 2024 revealed that resident #457 was dependent on staff for care.</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 - Some</p> | <p>- Resident #458 was admitted to the facility on [DATE] with a diagnosis of wedge compression fracture of first lumbar vertebra, enterocolitis due to clostridium difficile, urinary tract infection and orthostatic hypertension.</p> <p>Review of the MDS assessment dated , June 24, 2024 revealed a BIMS score of 14 which revealed no cognitive impairment. Further review revealed the resident required supervision or touching assistance with toileting and hygiene.</p> <p>Review of the care plan, dated June 27, 2024 revealed that resident #458 was a fall risk, had weakness, was unsteady on his feet and was dependent on staff.</p> <p>A grievance report was completed by resident #458 on July 30, 2024, involving an incident with staff #42. The report included resident #458 statement which stated that the CNA (staff #42) was very rude to the resident after he asked for assistance with wiping his bottom after toileting. The statement stated resident #458 struggled with wiping himself due to broken back that required him to wear a TLSO (thoracolumbar sacral orthosis) brace, which made it difficult to twist. The statement further stated, due to his orthostatic hypotension, he gets very dizzy and was scared of passing out or falling. The statement included that the CNA (staff #42) told resident #458 you're just trying to get an old black woman to wipe your ass. The report stated resident #458 did not want staff #42.</p> <p>An interview was conducted on October 9, 2024 at 10:44 AM with Staff #18, Resident Relations Manager. She stated she was the person who spoke with residents #456, #457, and #458 in regard to the grievances against staff #42. These incidents were brought to the attention of the Director of Nursing (DON, staff #28). It was verified from staff #18 that staff #42 was written up on</p> <p>October 1, 2024. Review of the Corrective Action Form revealed a fourth resident had complained about staff #42 which stated staff #42 would not help because resident was independent. The form also stated that the comment lead to resident feeling uncomfortable. Further review of the Corrective Action Form revealed that staff #42 was counseled, however she refused to sign the form.</p> <p>Review of the facility documentation revealed that all the mentioned incidents with staff #42 were not reported.</p> <p>An interview was conducted on October 9, 2024 with CNA, staff #43 who stated that abuse include resident not being covered up, not being changed and verbal abuse. Staff #43 stated it is 100% abuse when the staff member says you just want me to come in and wipe your ass? to any resident.</p> <p>An interview was conducted on October 9, 2024 at 1:06 PM with Licensed Practical Nurse (LPN, staff #40). Staff #40 stated that it is verbal abuse when the staff member says you just want me to come in and wipe your ass? to any resident.</p> <p>An interview was conducted on October 9, 2024 at 1:11 PM with DON (staff #28). Staff #28 stated that it is a lack of customer service and poor communication and incredibly rude when the staff member says you just want me to come in and wipe your ass? to any resident. Staff #28 stated that it was abuse only if the resident said they felt uncomfortable. When staff #28 was asked if she felt these incidents should have been reported, she stated No, only if it was stated they were uncomfortable should it have been reported.</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 - Some</p> | <p>The facility's policy on abuse dated 2022, version 0622 states If abuse is witnessed or suspected, reporting and investigation will take place in this manner:</p> <ol style="list-style-type: none"> 1. Executive Director (ED) will be notified. 2. ED and witness who is reporting will notify the following entities: <ol style="list-style-type: none"> A. Adult Protective Services B. Ombudsman C. State Survey Agency D. Law enforcement when applicable E. Facility Director of Nursing (DON) 3. DON will notify the following: <ol style="list-style-type: none"> A. Physician B. Responsible le Party C. VP of Clinical Operations 4. ED will begin investigation immediately and complete within 5 working days using the Abuse Investigation Packet. A minimum of three residents will be interviewed in order to determine if there is a trend. Interviews may also include the Alleged Perpetrator, Witnesses and Staff Members as applicable. 5. Suspected abuse will be reported in accordance with timeframe's and standards required by CMS. 6. If the alleged perpetrator is an employee, they will be immediately suspended pending the results of the investigation. 7. The resident suspected of being abused will be monitored and placed on alert charting. 8. When the investigation is complete, the ED will submit a summary to the entities in #2. 9. All abuse investigation information will be documented and logged according to facility protocol. |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49199</p> <p>Based on review of documentation, interviews and review of the facility policy, the facility failed to investigate and correct alleged violations of abuse for resident's (#456, #457 and #458) from one staff member (staff #42). The deficient practice could lead residents to suffer from psychosocial harm and further abuse of residents.</p> <p>Findings include:</p> <ul style="list-style-type: none"> - Resident #456 was admitted on [DATE] with a diagnosis of displaced intertrochanteric fracture of the right femur, chronic systolic heart failure, anxiety disorder, depression, acute pain due to trauma and tachycardia. <p>Review of the Minimum Data Set (MDS) assessment, dated April 4, 2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which revealed no cognitive impairment.</p> <p>Review of the care plan dated April 4, 2024, revealed that resident #456 was dependent on staff for care. An intervention included that the staff would converse with him while providing care.</p> <p>Review of the care plan dated April 11, 2024 revealed resident #456 was resistive to care. The goal was to demonstrate effective coping skills and encouraging him to participate as much as possible in his care.</p> <p>A grievance report was completed by resident #456 on May 22, 2024. It stated that resident #456 expressed CNA (Certified Nursing Assistant/ staff #42) was not qualified for her job and staff #42 told resident #456 I am 55 and I am not picking you up.</p> <ul style="list-style-type: none"> - Resident #457 was admitted to the facility on [DATE] with a diagnosis of acute cystitis, , anxiety disorder and depression and during her stay developed a urinary tract infection. <p>Review of the MDS assessment, dated July 11, 2024, revealed a BIMS score of 13 which revealed no cognitive impairment.</p> <p>A grievance report was completed by resident #457 on July 16, 2024, involving an incident with staff #42 on July 15, 2024. It stated Resident told day shift CNA that NOC (night shift) shift CNA, staff #42, got upset and was rude to patient about having to replace bed sheets after urine spilled on them from using the bed pan. Staff #42 was not assigned to resident #457 again.</p> <p>Review of the nursing progress note, dated July 16, 2024 at 12:38 PM stated that the resident #457 had some care issues the night before.</p> <p>Review of the care plan dated July 19, 2024 revealed that resident #457 was dependent on staff for care.</p> <p>(continued on next page)</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>- Resident #458 was admitted to the facility on [DATE] with a diagnosis of wedge compression fracture of first lumbar vertebra, enterocolitis due to clostridium difficile, urinary tract infection and orthostatic hypertension.</p> <p>Review of the MDS assessment dated , June 24, 2024 revealed a BIMS score of 14 which revealed no cognitive impairment. Further review revealed the resident required supervision or touching assistance with toileting and hygiene.</p> <p>Review of the care plan, dated June 27, 2024 revealed that resident #458 was a fall risk, had weakness, was unsteady on his feet and was dependent on staff.</p> <p>A grievance report was completed by resident #458 on July 30, 2024, involving an incident with staff #42. The report included resident #458 statement which stated that the CNA (staff #42) was very rude to the resident after he asked for assistance with wiping his bottom after toileting. The statement stated resident #458 struggled with wiping himself due to broken back that required him to wear a TLSO (thoracolumbar sacral orthosis) brace, which made it difficult to twist. The statement further stated, due to his orthostatic hypotension, he gets very dizzy and was scared of passing out or falling. The statement included that the CNA (staff #42) told resident #458 you're just trying to get an old black woman to wipe your ass. The report stated resident #458 did not want staff #42.</p> <p>An interview was conducted on October 9, 2024 at 10:44 AM with Staff #18, Resident Relations Manager. She stated she was the person who spoke with residents #456, #457, and #458 in regard to the grievances against staff #42. These incidents were brought to the attention of the Director of Nursing (DON, staff #28). It was verified from staff #18 that staff #42 was written up on</p> <p>October 1, 2024. Review of the Corrective Action Form revealed a fourth resident had complained about staff #42 which stated staff #42 would not help because resident was independent. The form also stated that the comment lead to resident feeling uncomfortable. Further review of the Corrective Action Form revealed that staff #42 was counseled, however she refused to sign the form.</p> <p>Review of the facility documentation revealed that all the mentioned incidents with staff #42 were not reported. Further, the facility was unable to provide any documentation that the above incidents were investigated at the time they occurred.</p> <p>An interview was conducted on October 9, 2024 with CNA, staff #43 who stated that abuse include resident not being covered up, not being changed and verbal abuse. Staff #43 stated it is 100% abuse when the staff member says you just want me to come in and wipe your ass? to any resident.</p> <p>An interview was conducted on October 9, 2024 at 1:06 PM with Licensed Practical Nurse (LPN, staff #40). Staff #40 stated that it is verbal abuse when the staff member says you just want me to come in and wipe your ass? to any resident.</p> <p>An interview was conducted on October 9, 2024 at 1:11 PM with DON (staff #28). Staff #28 stated that it is a lack of customer service and poor communication and incredibly rude when the staff member says you just want me to come in and wipe your ass? to any resident. Staff #28 stated that it was abuse only if the resident said they felt uncomfortable. When staff #28 was asked if she felt these incidents should have been reported, she stated No, only if it was stated they were uncomfortable should it have been reported.</p> <p>(continued on next page)</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>The facility's policy on abuse dated 2022, version 0622 states If abuse is witnessed or suspected, reporting and investigation will take place in this manner:</p> <ol style="list-style-type: none"> 1. Executive Director (ED) will be notified. 2. ED and witness who is reporting will notify the following entities: <ol style="list-style-type: none"> A. Adult Protective Services B. Ombudsman C. State Survey Agency D. Law enforcement when applicable E. Facility Director of Nursing (DON) 3. DON will notify the following: <ol style="list-style-type: none"> A. Physician B. Responsible le Party C. VP of Clinical Operations 4. ED will begin investigation immediately and complete within 5 working days using the Abuse Investigation Packet. A minimum of three residents will be interviewed in order to determine if there is a trend. Interviews may also include the Alleged Perpetrator, Witnesses and Staff Members as applicable. 5. Suspected abuse will be reported in accordance with timeframe's and standards required by CMS. 6. If the alleged perpetrator is an employee, they will be immediately suspended pending the results of the investigation. 7. The resident suspected of being abused will be monitored and placed on alert charting. 8. When the investigation is complete, the ED will submit a summary to the entities in #2. 9. All abuse investigation information will be documented and logged according to facility protocol. |

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| <p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43863</p> <p>Based on clinical record review, staff interviews, and policy reviews, the facility failed to ensure three of four sampled residents (#14, #4, #40) were administered scheduled pain medication in accordance with the physician order. The deficient practice could result in residents' pain not being adequately controlled.</p> <p>Findings Include:</p> <p>-Regarding Resident #14:</p> <p>Resident #14 was initially admitted on [DATE] with diagnoses that included COPD, displaced fracture of 5th cervical vertebra, major depressive disorder, and insomnia.</p> <p>A care plan initiated on July 16, 2021 revealed that the resident has chronic pain and takes an opioid and non-opioid analgesic related to chronic pain of the bilateral lower extremities. Interventions that were initiated on March 4, 2021, indicated to administer analgesia medication as per orders.</p> <p>Physician orders revealed the following:</p> <p>-Dated April 5, 2022: Oxycodone HCl Tablet 15 mg (milligram), give 15 mg by mouth (PO) every 4 hours as needed for pain level 4-10 out of 10.</p> <p>-Dated July 10, 2024: Opioid Use: Monitor for constipation, signs/symptoms of delirium/over sedation, change in mental status, and reduced respirations every shift for opioid usage.</p> <p>Review of an Annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. The assessment also revealed that the resident received pain medications (PRN) as needed, had frequent pain and received opioids.</p> <p>Review of the Medication Administration Record (MAR) dated September 2024, revealed evidence that Oxycodone had been administered for pain levels of 0, which were outside of the provider orders on the following dates:</p> <p>-9/23/2024 at 20:02PM.</p> <p>-9/24/2024 at 1915 PM.</p> <p>-9/25/2024 at 1930 PM.</p> <p>-9/26/2024 at 1942 PM.</p> <p>-9/27/2024 at 1819 PM.</p> <p>-9/30/2024 at 1850 PM.</p> <p>(continued on next page)</p> | | |

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| <p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Further review of the clinical record revealed no evidence that the provider had been notified that Oxycodone had been administered outside of parameters on those dates.</p> <p>Continued review of the clinical record revealed no evidence of post administration pain assessments on the above dates.</p> <p>Review of the MAR, dated October 2024, revealed evidence that Oxycodone had been administered for pain levels less than 4, which were outside of the provider orders:</p> <p>-October 2, 2024 at 19:20 PM: pain level 0</p> <p>-October 5, 2024 at 19:30 PM: pain level 2</p> <p>Review of the clinical record on October 2, and October 5, 2024, revealed no evidence that the provider had been notified regarding administration of Oxycodone outside of parameters.</p> <p>Further review of the clinical record on October 2, and October 5, 2024, revealed no evidence of post administration pain assessments.</p> <p>An interview was conducted on October 09, 2024 at 12:00 PM with a Licensed Practical Nurse (LPN/staff #40), who stated that she expected nurses to follow physician orders as written including any parameters. She stated that when administering oxycodone, nurses assess the resident's pain levels prior to, and 30-60 minutes after administering the medication, and document the results in a progress note. The LPN also stated that when a resident requests oxycodone outside of parameters the LPN would notify the provider and document in a progress note. The LPN also stated that Resident #14 is alert and is able to make his needs known regarding pain and pain medication, and he typically requests it in the morning and at night. The LPN reviewed the clinical record and stated that there was an order for Oxycodone to be administered every 4 hours as needed for a pain level of 4-10, PRN. She also stated that Oxycodone should not be administered for a pain level less than 4 as written in the provider orders, and that the resident had an order for Tylenol for pain levels of 1-3. The LPN reviewed the October 2024 MAR and stated that Oxycodone had been administered for pain level of 0 on October 2, 2024, and for a pain level of 2 on October 5, 2024, and that the Oxycodone had been administered outside of physician ordered parameters. She further stated that there was no evidence in the progress notes of pain follow up within the hour after administration, or that the provider had been notified. The LPN reviewed the September 2024 MAR and stated that Oxycodone had been administered for a pain level of 0 on 6 occasions, and that this did not follow the providers orders, and there was no evidence in the clinical record that the provider had been notified. She further stated that there was no evidence that a post-administration pain assessment had been completed an hour after the medication had been administered. The LPN further stated that this did not meet the facility process, and that the risk of administering oxycodone outside of the ordered parameters could result in over medication, make it difficult to determine if the medication is effective, and the provider would not be aware if the patient required a new medication order.</p> <p>(continued on next page)</p> | | |

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| <p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>An interview was conducted on October 9, 2024 at 03:09 PM with the Director of Nursing (DON/staff #28), who stated that she expected medications to be administered as written in the provider orders, including parameters. She also stated that the provider should be notified prior to any medication being administered outside of parameters, and the call should be documented in a progress note. The DON reviewed the clinical record and stated that there was an order for Oxycodone 15 mg to be administered every 4 hours, PRN for a pain level of 4-10 out of 10 (4-10/10). She also stated that she expected that the provider would have been notified for medication administration outside of the parameters. She reviewed the October 2024 MAR and stated that Oxycodone had been administered outside of the ordered parameters on October 2, 2024 and October 5, 2024, and there was no evidence in the clinical record that the provider had been notified. The DON reviewed the September 2024 MAR and stated that there were six occasions that Oxycodone had been administered for a pain level of 0, and that this did not meet the provider orders. She also stated that there was no evidence that the provider had been notified, or that a post-administration pain assessment had been completed. The DON further stated that this did not meet her expectation regarding Oxycodone administration. The DON stated that the risk of administering Oxycodone outside of provider orders could result in the physician not being aware that the patient was receiving medication outside of the parameters.</p> <p>-Regarding Resident #4</p> <p>Resident #4 was admitted on [DATE] with diagnoses that included opioid dependence, cerebral infarction, post-traumatic stress disorder, major depressive disorder, depression, anxiety disorder, and history of transient ischemic attack (TIA).</p> <p>An Initial Care Plan dated September 13, 2024 with a focus of opiate medication included an intervention to administer medication as ordered.</p> <p>A 5-day Medicare Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 09, which indicated moderate cognitive impairment. The assessment included that the resident had almost constant pain, that interfered with sleep and day-to-day activities.</p> <p>Provider orders revealed the following:</p> <ul style="list-style-type: none"> - Roxicodone Oral (Oxycodone HCl) tablet 5 mg (milligram), give 1 tablet by mouth every 4 hours as needed (PRN) for pain 1-10/10, dated September 13, 2024, discontinued September 15, 2024. - Roxicodone Oral (Oxycodone HCl) Tablet 5 mg, give 2 tablets by mouth every 4 hours PRN for pain 6-10/10, dated September 15, 2024 and discontinued on October 1, 2024. <p>Review of the September 2024 MAR revealed evidence that Roxicodone 5mg tablet had been administered outside of the ordered parameters for a pain level of 0 on 24 occasions during the month.</p> <p>Review of progress notes revealed no evidence that the provider had been notified that Roxicodone had been administered outside of parameters on 22 of the 24 occasions that the medication had been administered outside of parameters.</p> <p>Further review of provider orders dated October 1, 2024, revealed an order for Oxycodone HCl oral tablet 15 mg, give by mouth every 4 hours PRN for pain level 5 - 10.</p> <p>(continued on next page)</p> | | |

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| <p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of October 2024 MAR revealed the following administration of Oxycodone 15 mg tablets outside of the ordered parameters:</p> <ul style="list-style-type: none"> -Pain level of 0, three times, on October 2, October 3, and October 4, 2024. -Pain level of 3, one time, on October 3, 2024. <p>Further review of the October 2024 MAR revealed the following administration of Roxicodone 5 mg tablets outside of the ordered parameters:</p> <ul style="list-style-type: none"> -Pain level of 0 on October 1, 2024 at 01:36 AM and 05:27 AM. <p>Review of the clinical record revealed no evidence that the provider had been notified that Oxycodone or Roxicodone had been administered outside of parameters in October 2024.</p> <p>An interview was conducted on October 10, 2024 at 09:30 AM, with an LPN (staff #64), who stated that the facility expectation is to follow provider orders as written, including parameters. She also stated when a medication is administered outside of parameters the provider should be notified, and the contact should be documented in progress notes. The LPN stated that Resident #4 has considerable pain and requests pain medication every 4 hours. The LPN reviewed the clinical record and confirmed the provider orders for Oxycodone dated 10/2/2024, for 15 mg every 4 hours as needed for a pain level of 5-10. She reviewed the October 2024 MAR and stated that Oxycodone had been administered outside of parameters on 4 occasions. She further stated that there was no evidence in the clinical record that the provider had been notified on any of the 4 occasions Oxycodone had been administered outside of parameters. The LPN further reviewed the clinical record and stated there were provider orders for Roxicodone 5mg tablet, every 4 hours for pain 6-10/10, ordered on September 15, 2024 and discontinued on October 1, 2024. She reviewed the September 2024 and October 2024 MAR and stated that Roxicodone had been administered outside of parameters for a pain level of 0 on 2 occasions in October, and for a pain level of 0 in September on 24 occasions. She further stated that there was no evidence in the clinical record that the provider had been notified regarding administration of Roxicodone outside of parameters during October or during September for 22 of the 24 times that the medication had been administered outside of parameters. The LPN stated that Roxicodone and Oxycodone had not been administered following provider orders. She further stated that the risk of administering Oxycodone/Roxicodone outside of the ordered parameters could result in lethargy, and in this resident's case, it could exacerbate an opioid dependence.</p> <p>(continued on next page)</p> | | |

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| <p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>An interview was conducted on October 10, 2024 at 10:07 AM with the DON (staff #28), who stated that Oxycodone had been ordered to be administered for a pain level of 5-10. She reviewed the October 2024 MAR and stated that Oxycodone had been administered outside of parameters, for a pain level of 0 on 4 occasions, and that this did not meet the policy for medication administration. She also reviewed the clinical record and stated that there was no evidence that the provider had been notified. The DON stated that the resident had an order for Roxycodone to be administered for pain level of 6-10/10. She reviewed the October 2024 MAR and stated that Roxycodone had been administered outside of parameters twice in October for a pain level of 0. The DON reviewed the September 2024 MAR and stated that there was evidence that Roxycodone had been administered outside of the provider ordered parameters on 24 occasions in September, and there was no evidence in the clinical record that the provider had been notified on 22 of the 24 occasions. The DON also stated that the resident had a diagnosis of opioid dependence, and the risk could result in not following provider orders, or communicating with the provider. The DON further stated that she spoke with the nurse that administered most of the medications and that he was not documenting correctly. She further stated that he was not documenting the actual pain level at the time the medication had been administered, but was instead documenting the follow-up pain level. The DON stated that the nurse had been trained on how to administer medications, and trained with several nurses for a couple of weeks during orientation. She also stated that during orientation staff are educated on MAR documentation process.</p> <p>51103</p> <p>Regarding Resident #40:</p> <p>Resident # 40 was admitted on [DATE] with diagnoses that included acute osteomyelitis, polyneuropathy, heart failure, hypertension, and Type 2 Diabetes Mellitus.</p> <p>A review of the physician's orders dated 9/23/24 called for a pain evaluation to be conducted every shift for Pain Scale 0-10.</p> <p>A review of resident's Medication Administration Record (MAR) revealed an order dated 9/23/24 for an Oxycodone 10 mg tablet to be given by mouth every six hours as needed for a pain level of 7-10. The MAR also revealed an order dated 9/23/24 for an Oxycodone 5 mg tablet to be given every 6 hours as needed for pain level of 4-6.</p> <p>A review of the resident's care plan initiated on 9/23/24 acknowledged resident use of opioids for pain control. Care plan intervention included the administration of analgesia medication as per orders.</p> <p>A review of resident's pain graph from 9/24/24 to 10/1/24 quantified resident pain level as 0, every day except 9/28/24 at 22:47, where the resident reached a level of 8 on a scale of 0-10.</p> <p>Further review of the MAR revealed a tablet of Oxycodone 10 mg was given on 9/27/24 at 20:57, and additionally at 9/30/24 at 21:40 by Registered Nurse (RN)/Staff #22 with a recorded resident pain level of 0.</p> <p>(continued on next page)</p> | | |

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| 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 10/10/2024 |
| 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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>A review of resident's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which suggested resident was cognitively intact. The MDS further recorded the resident's highest pain over the last 5 days was an 8, and also stated that pain occasionally limited the resident's day to day activities.</p> <p>A review of resident's Medication Record Review dated 9/30/24, stated to monitor pain, efficacy, and opioid-related side effects related to oxycodone use.</p> <p>Review of a Nurse Practitioner (NP) progress note dated 10/9/24 at 8:26 am, stated the resident was informed about the risk of opioid medications. It further stated the goal for resident was to discontinue opioid use within the next 7-10 days.</p> <p>Review of the Prescriber's Arizona Medical Board record dated 10/10/24 revealed the provider's specialty as Pain Medicine, with an active license status due to renew 3/23/25.</p> <p>In an interview conducted 10/10/24 at 9:10 am with Certified Nurse Assistant (CNA) /Staff #61, stated that is the responsibility of the CNA to immediately report to the nurse if a resident verbally or physically is showing signs of pain. CNA further voiced an additional responsibility was to ensure that resident was as comfortable as possible.</p> <p>In an interview conducted October 10, 2024 at 9:18 am with Registered Nurse (RN) /Staff # 26 revealed that if opioid administration is dependent upon the resident pain level, the medication should be withheld if pain level is outside of the ordered parameter.</p> <p>On October 10, 2024 at 9:22 am, the Director of Nursing (DON)/Staff #28 reviewed the resident MAR for September 2024. The DON identified two incidents of Oxycodone administered to the resident, when recorded pain level was recorded as a zero. The DON acknowledged that the medication should not have been given outside of the ordered parameter. DON attributed a precipitating factor for the misadministration was nurse's new graduate status. DON stated she has already re-educated the nurse on the proper administration of medications within parameter.</p> <p>According to policy titled Administering Oral Medications, the nurses are required to perform any pre-administration assessments, and to check, and recheck to confirm proper medication dose.</p> <p>The facility policy titled, Pain Management: Pain Assessment and Management, revealed that the medication regimen is implemented as ordered, results of the interventions are documented and communicated directly to the provider when appropriate. Ongoing communication between the prescriber and the staff is necessary for the optimal and judicious use of pan medications. Document the resident's pain level with adequate detail, record the information in the resident's medical record.</p> | | |

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| <p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50166</p> <p>Based on personnel file review, staff interview, and facility policy review, the facility failed to ensure that three of three sampled Certified Nursing Assistants (CNA/ Staff#48, Staff#61, and Staff#42) maintained valid Cardiopulmonary Resuscitation (CPR) and first aid certifications. The deficient practice could result in potential harm to residents due to staff not being knowledgeable about how to provide emergency care to residents as part of the CPR team.</p> <p>Findings include:</p> <p>Review of the personnel file for a CNA (Staff#48) revealed a hire date and signed job description on [DATE]. Continued review of the personnel file revealed no evidence that Staff #48 obtained a CPR or First Aid certification.</p> <p>Review of the personnel file for a CNA (Staff#61) revealed a hire date of [DATE], and a signed job description on [DATE]. Continued review of the personnel file revealed no evidence that Staff #61 obtained a CPR or First Aid certification.</p> <p>Review of the personnel file for a CNA (Staff#42) revealed a hire date and signed job description on February 27, 2024. Continued review of the personnel file revealed no evidence that Staff #42 obtained a CPR or First Aid certification.</p> <p>Review of the CNA job description revised in September of 2016 that was signed by all certified nursing assistants at the facility revealed that an Active, Class-Instructed CPR Certification was a Minimum Requirement for the position.</p> <p>Review of a new CNA job description was presented during an interview and revealed that on this new document, the CPR certification was preferred and not required. The job description did not have an effective date listed, and there was no evidence that any CNA in the building had signed or used it.</p> <p>On [DATE] at 1:08 p.m., an interview was conducted with the Director of Nursing (DON/Staff#28) who stated that CNAs did not need to have a CPR card, and only nurses do. Staff #28 was shown the job description that revealed a CPR certification was a requirement for the CNA position and she stated she was going to review the personnel files for staff #48 and #61 to see if they had obtained CPR certifications. Staff #28 stated she did not think staff #48, #61, or any CNA in the building had a CPR certification.</p> <p>On [DATE] at 2:11 p.m., an interview was conducted with the Corporate HR Operations Manager (Staff#70) who stated that a new policy and new job description for CNA ' s was put in place starting [DATE], and did not require CNA ' s to be CPR certified. Staff #70 gave an undated copy of the new job description and stated that CPR was a preference, not a requirement. Staff #70 stated that anyone hired as of [DATE] would have signed the new job description. Staff #70 was shown two examples of CNA job descriptions hired after [DATE], and stated that both CNA ' s signed the incorrect job description.</p> <p>(continued on next page)</p> | | |

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| <p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>On [DATE], an interview was conducted with Human Resources (HR/Staff#58) who stated that none of the CNA ' s hired after [DATE] had signed the new job description.</p> <p>Review of the facility policy effective on [DATE] titled, Emergency/First Aid: Emergency Procedure - Cardiopulmonary Resuscitation (CPR) revealed that the facility ' s CPR team shall include at least one nurse, one LPN/LVN, and two CNAs, all of whom have received training and certification in CPR/BLS. The policy also revealed that there should have been an identified CPR team for each shift in the case of an actual cardiac arrest.</p> |