STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035091	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Flagstaff	800 West University Avenue Flagstaff, AZ 86001

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911 Based on clinical record reviews, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure that two residents (#1 and #2) were free from physical abuse. The deficient practice could result in further incidents of resident to resident abuse. Findings include: -Regarding resident #1 Resident #1 was admitted on [DATE] with diagnosis including displaced intertrochanteric fracture of the right femur, low back pain, unsteadiness on feet, hypertension, unspecified glaucoma, major depressive disorder-recurrent, insomnia, type 2 diabetes with neuropathy, muscle wasting and atrophy, abnormalities of gait and mobility, osteoporosis, repeated falls and urinary tract infection. A review of the admission MDS (minimum data set) dated January 6, 2021 revealed a BIMS (brief interview of mental status) score of 00, indicating severe cognitive impairment. -Regarding resident #2 Resident #2 was admitted on [DATE] with diagnosis including unspecified fracture of right femur, repeated falls, unspecified dementia, type 2 diabetes, monoplegia of upper limb, facial weakness, other cerebral infarction due to occlusion or stenosis. A review of the progress notes revealed an entry, that on January 28, 2021 an altercation took place between resident #1 and #2. It was noted that both residents were sitting in their wheelchairs prior to the altercation. It was further noted that a PTA (physical therapy assistant) was maneuvering resident #2 around the dining table and upon passing resident #1, resident #2 starting hitting resident #1 with her left upper extremity. It was noted that resident #2 kept hitting resident #1 and then resident #1 starting hitting back in self-defense. Staff (PTA) alerted other staff to the incident and the residents were separated. It was noted that the residents were assessed for injuries and none were present. The progress notes further revealed that an LPN (Licensed Practical Nurse/ staff #22) notified the previous ADON (Assistant Director of Nursing) and he called the Arizona State Board of Nursing, leaving a voicemail regarding the incident and that case managers and family members were notified. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	However, there is no documented evidence that the incident was reported to the state survey agency. An interview was conducted on October 22, 2023 at 2:15 P.M. with CNA (certified nursing assistant/ Staff #18). Staff #18 stated that abuse could be mental, financial, verbal, neglect or physical. She stated that the facility has annual training but also provides monthly training refreshers. Staff #18 stated that if abuse is observed between residents, the first thing that is done is to physically separate the residents and ensure their safety. Residents may need to be moved to another room, if they were sharing a room. She further stated that once residents are safe, notifications and an incident report would occur and that these are time sensitive and would need to happen right away. Stated that she had received training on abuse and behavioral health. A telephonic interview was conducted on October 22, 2023 at 2:50 P.M. with an LPN (Staff #22). Staff # 22 stated that she had recollection of the incident, but given that it was in 2021, no longer recalled the specifics of what had occurred. An interview was conducted on October 23, 2024 at 1:40 P.M. with staff #115 (LPN). Staff #115 stated that if an altercation occurred between residents, they are immediately separated and she and other staff would check to make sure they are safe and not injured. If additional assistance was needed, staff know to call for help. Once residents are safe, the director of nursing is notified and the facility proceeds with notifications of family, physician, case manager as well as filling a complaint report. She stated that she believed that the notification window was a 2-hour time span for incidents of abuse. Staff #115 further stated that the facility conducts training regarding abuse at least annually, but usually more frequently. An interview was conducted on October 23, 2024 at 8:30 A.M. with staff #28 , DON (director of nursing). Staff #28 stated that the expectation is that resident to resident abuse does not occur; however with certain diagnosis behaviors [NAME] always predictable. She further stated that when an incident does occur, the facility is required to report incidents on a timely basis and follow-up with a thorough investigation. She stated that the risk of resident to resident abuse could result in injury to a resident. A review of the facility policy entitled Abuse, with a copywrite date of 2022, version 0622 revealed that abuse is not condoned in Haven Health facilities.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911 Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to submit a 5-day written investigation summary regarding physical altercation between 2 residents (#1 and #2). The deficient practice could result in allegations of abuse not being investigated. Findings include: -Regarding resident #1 Resident #1 was admitted on [DATE] with diagnosis including displaced intertrochanteric fracture of the right femur, low back pain, unsteadiness on feet, hypertension, unspecified glaucoma, major depressive disorder-recurrent, insomnia, type 2 diabetes with neuropathy, muscle wasting and atrophy, abnormalities of gait and mobility, osteoporosis, repeated falls and urinary tract infection. A review of the admission MDS (minimum data set) dated January 6, 2021 revealed a BIMS (brief interview of mental status) score of 00, indicating severe cognitive impairment. -Regarding resident #2 Resident #2 was admitted on [DATE] with diagnosis including unspecified fracture of right femur, repeated falls, unspecified dementia, type 2 diabetes, monoplegia of upper limb, facial weakness, other cerebral infarction due to occlusion or stenosis. A review of the progress notes revealed an entry, that on January 28, 2021 an altercation took place between resident #1 and #2. It was noted that both residents were sitting in their wheelchairs prior to the altercation. It was further noted that a PTA (physical therapy assistant) was maneuvering resident #2 around the dining table and upon passing resident #1, resident #2 starting hitting resident #1 with her left upper extremity. It was noted that resident #2 kept hitting resident #1 and then resident #1 starting hitting back in self-defense. Staff (PTA) alerted other staff to the incident and the residents were separated. It was noted that the residents were assessed for injuries and none were present. The progress notes further revealed that an LPN staff#22 notified the previous ADON and he called the Arizona State Board of Nursing, leaving a voicemail regarding the incident and that case managers and family members were notified; however, there is no documented evidence that the incident was reported to the state survey agency. Given that the incident occured in 2021, several of the staff members who witnessed the incident are no longer with the facility An interview was conducted on October 22, 2023 at 2:15 P.M. with staff #18 CNA (certified nursing assistant). Staff #18 stated that abuse could be mental, financial, verbal, neglect or physical. She stated that the facility has annual training but also provides monthly training refreshers. Staff # stated that if abuse is observed between residents, the first thing that is done is to physically separate the residents and ensure their safety. Residents may need to be moved to another room, if they were sharing a room. She further stated that once residents are safe, notifications and an incident report would occur and that these are time sensitive and would need to happen right away. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephonic interview was conducted on October 22, 2023 at 2:50 P.M. with staff #22, LPN (licensed practical nurse). Staff # 22 stated that she had recollection of the incident, but given that it was in 2021, no longer recalled the specifics of what had occurred. An interview was conducted on October 23, 2024 at 1:40 P.M. with staff #115 LPN (licensed pratical nurse). Staff #115 stated that if an altercation occurred between residents, they are immediately separated and she and other staff would check to make sure they are safe and not injured. If additional assistance was needed, staff know to call for help. Once residents are safe, the director of nursing is notified and the facility proceeds with notifications of family, physician, case manager as well as filling a complaint report. She stated that she believed that the notification window was a 2-hour time span for incidents of abuse. Staff #115 further stated that the facility conducts training regarding abuse at least annually, but usually more frequently. She stated that the risk for not reporting timely or conducting an investigation, could impact finding out what actually happened and requirements regarding timely reporting. An interview was conducted on October 23, 2024 at 8:30 A.M. with staff #28 DON (director of nursing). Staff #28 stated that the facility is required to report incidents on a timely basis and follow-up with a thorough investigation. She stated that the facility was unable to locate the 5-day investigation of the incident regarding resident #1 and resident #2 and that these records might be in storage. She stated that she was fairly certain that a 5-day investigative report would have been completed and that she would look in the facilities storage facility for the investigative report. She stated that if the 5-day investigation was not completed then the risk would include not knowing what actually transpired and not meeting timely reporting guidelines. On October 25, 2024 at 5:35 P.M. an email was received from the Executive Director, staff #42. The email noted that the facility was unable to find the 5-day investigative report regarding this incident. There was no evidence that the 5-day investigative summary had been submitted to the state survey agency. A review of the facility policy entitled Abuse with a copywrite date of 2022 version 0622 noted that the executive director will begin an investigation immediately and complete the incident investigation within 5-working days utilizing an abuse investigation packet. It was further noted that this summary is then sent to the state survey agency;

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911 Based on observation, interview, and record review the facility failed to ensure that one resident (#3) received care for pressure ulcers consistent with professional standards when observed wound care assessments were not completed on a weekly basis. This had the potential for pressure ulcers for resident #3 to worsen. Findings include: Resident #3 was admitted on [DATE] with diagnosis including venous insufficiency (chronic-peripheral), pressure ulcer of the left heel (unstageable), pressure ulcer of the right heel (unstageable), acute posthemorragic anemia and cellulitis of the left lower limb. A review of the discharge MDS (minimum data set) dated March 10, 2021 revealed no BIMS (brief interview of mental status) score. A review of the physician orders revealed orders for daily wound care to both right/ left heels and posterior right/ left calf. Orders were further observed for physical and occupational therapy. An order dated March 10, 2021 was also observed for a consult for heel debridement. A review of the care plan revealed that the resident had a DTI (deep tissue injury) to bilateral heels and had the potential for further pressure ulcer development due to decreased mobility. The noted intervention included to access, record and monitor wound healing weekly and as necessary. It further noted that length, depth and width would be measured when possible and that all assessments would be documented. The care plan further revealed that the resident had limited mobility due to right hand and bilateral lower extremity contractures. The intervention included referral to physical and occupational therapy as well as monitoring and documentation of contractures forming or worsening. The electronic health record for the resident revealed a time span greater than 7-days for pressure ulcer documentation and assessment for the following assessments: January 25, 2021, February 4, 2021 and February 27, 2021. An interview was conducted on October 22, 2024 with staff #115, LPN (licensed practical nurse). Staff #115 stated that that skin assessments are conducted weekly and documented in the electronic health record. She stated that the risk for not completing the assessment or not completing it timely would include not knowing what is going on with the resident in relationship to wound care or the wound worsening. An interview was conducted on October 23, 2024 at 10:30 A.M. with staff #72 (ADON-assistant director of nursing and wound care nurse). Staff #72 stated that upon admission, residents with wounds are placed on weekly wound care rounds with the physician or nurse practitioner. She stated that assessments are conducted weekly but sometimes more often contingent on what is going on with the pressure ulcer. Staff #72 stated that the risk for not having assessments completed weekly would be contingent on the resident's comorbidities. She stated the facility now has a program in place called PUP (pressure ulcer prevention) and that this has been very helpful in reducing the number of facility acquired pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on October 23, 2024 at 10:40 A.M. with staff #28 DON (director of nursing). Staff #28 stated that the expectation is that pressure ulcer and skin assessments be completed weekly, as per policy. She stated that wound care and more specifically pressure ulcers were current QAPI (quality assurance and performance improvement) measures for the facility. Staff #28 reviewed the residents electronic health record and confirmed that the assessments were not consistent on a week to week basis for resident #3. She stated that the risk for not conducting weekly assessments timely could include a worsening of the pressure ulcer or wound. Facility evidence, to include a performance improvement plan for the improvement of pressure ulcer and wound management in 2022 revealed that the facility was actively pursuing a reduction of incidences and severity of pressure ulcers and wounds, seeking to minimize the risk of infection to ensure consistent and proactive care for residents. The plan detailed appointment of a wound coordinator to oversee and monitor outcomes, discussion of high-risk residents in interdisciplinary meetings, a review of trends during quality assurance and performance improvement meetings, and development of a standardized protocols in measuring and documenting wound size, depth and condition. The plan further outlined proactive interventions, infection control measures, goals and outcomes as well as evaluation of the plan by data analysis and to further delineate areas for continuous improvement. The plan further included in-service documentation. Data collection was observed from March 2022 through May 2022. Analysis of the data revealed that there were facility acquired wounds and some wounds were noted to have gotten worse, with improvement of wounds noted upon replacement of the wound nurse and integration of the PUP (pressure ulcer prevention) program. Subsequent data for June, July and August of 2022 revealed a significant amount of healing with completion of weekly wound reports noted to be at 100% for the 3-month interval. A review of the facility policy entitled Skin/Wound Management: Pressure Injury Risk Assessment with an effective date of January 1, 2024 revealed that the resident is to be assessed at admission and that the risk assessment is to be completed weekly thereafter; however, facility documentation did not reveal evidence of consistent weekly assessments. Given the integration of the aforementioned performance improvement plan in 2022, this citation is noted to be for past non-compliance.