

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2025
NAME OF PROVIDER OR SUPPLIER Haven of Flagstaff		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of records, and review of facility policy and procedure, the facility failed to ensure one resident (#10) was free from a preventable accident that resulted in serious injury. The deficient practice could lead to further instances of accidents resulting in injuries to residents.</p> <p>Findings include:</p> <p>Resident #10 was admitted on [DATE], with diagnoses that included acute kidney failure, cardiac murmur, repeated falls, difficulty in walking, and age-related osteoporosis.</p> <p>A quarterly minimum data set (MDS) assessment dated [DATE], revealed that the resident had a brief interview for mental status (BIMS) score of 4, indicating the resident had severe cognitive impairment.</p> <p>A physician order dated March 22, 2025, indicated for a right ankle boot for possible calcaneal stress fracture, and to repeat right ankle x-ray the week of April 7, 2025.</p> <p>A care plan dated April 16, 2025, revealed that the resident had or was at risk for having functional mobility deficits or functional mobility limitations, with an intervention that the resident required a hooyer lift for transfers. There was no evidence of a care plan for transfers prior to this date.</p> <p>An Incident (Risk Management) Report dated March 20, 2025, revealed that an incident occurred in the common bathroom, the resident then reported right ankle pain. The resident speaks mostly Navajo, and that a translator asked the resident what had happened. The resident stated that her right foot was hurt during a transfer. The right ankle was swollen, warm, and painful to the touch. The resident was sent to the hospital for an x-ray. Additionally, spoke with the CNA about safe transfers, slowing down, listening to residents, and removing the foot pedals of the wheelchair during transfers.</p> <p>A Change of Condition Summary note dated March 20, 2025, revealed that the nurse was informed by another nurse that the resident was having difficulty with transfers. The resident reported right ankle pain. This nurse assessed the resident, and the right foot was swollen and painful to the touch. The resident was sent out to the hospital for an x-ray.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 035091	If continuation sheet Page 1 of 4

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A Physician Progress Note dated March 22, 2025, revealed that the provider was asked to see the resident after her right ankle was recently caught up in the wheelchair during a transfer. The resident was assessed for traumatic right ankle pain. The x-ray of the right ankle revealed a possible stress fracture of the calcaneus. Recommended was an ACE wrap, a walking boot, and a follow-up x-ray the week of April 7th.</p> <p>An additional Incident Report, dated April 12, 2025, revealed that a CNA (Staff #30) and a med tech (Staff #46) notified the nurse that Resident #10 sustained an injury while being transferred by one-person assistance from the wheelchair to the bed. The CNA who transferred the resident stated that an audible pop or crack occurred during the transfer and that the resident reported severe pain to the left lower extremity.</p> <p>A witness statement by Staff #30, dated April 13, 2025, revealed on April 12, at 7:30 PM, Staff #30 transferred Resident #10 from wheelchair to bed. The resident's left foot bent to the left from the CNA's right leg and made a popping sound. Additionally, it was a 2 second transfer. The nurse was notified and assessed the resident.</p> <p>Another witness statement by Staff #46, dated April 12, 2025, revealed the CNA came out of the room stating that while transferring Resident #10, he heard a pop / crack noise. Staff #46 entered the room, and Resident #10 cried out and stated in Navajo that it really hurts. The nurse was notified, and the resident went to the hospital.</p> <p>A progress note dated April 12, 2025, revealed at 7:35 PM, this writer was approached by a med tech and certified nursing assistant (CNA) stating that Resident #10 was possibly injured during a wheelchair to bed transfer. Upon assessment, the resident was found lying on the bed, and complaining of severe pain to the left lower extremity and swelling was noted. The provider and the Assistant Director of Nursing (ADON) were notified, and instructed to send the resident to the ED for evaluation. The resident was sent to the hospital. At approximately 11:00 PM, this writer received a call from the hospital nurse and was informed that the resident sustained tibia and fibula fractures. Per the hospital nurse, the extremity has been splinted and the resident is scheduled for surgery in the morning on April 13, 2025.</p> <p>A supplemental training in-service, dated April 15, 2025, revealed that Staff #30 signed that he had completed transfer training and was confident with this skill. If Staff #30 would like more training, to seek out the Director of Rehab, the Director of Nursing, or anyone on the clinical leadership team. Additionally, the in-service statement revealed it is important to take time, remove or add any equipment on the mobility device, follow patient care plan, use a gait belt, 2-person assist, or hoist if indicated.</p> <p>A History and Physical note from the hospital dated April 13, 2025, revealed the resident was transferred from the facility, and staff state they were transferring the resident from chair to bed and her left leg got caught on something and they heard a pop. Left lower leg hematoma was noted. Orthopedics has been consulted, and plans are for the operating room in the morning. X-ray of the left leg revealed spiral nondisplaced fractures of the midshaft and fibula and distal shaft of the tibia.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A telephonic interview was conducted with a med tech (CMA / Staff #46) on April 29, 2025, at 10:04 AM, Staff #46 stated she was outside the resident's door in the hallway, passing medication. She stated she heard Resident #10 crying. Staff #46 was then informed by Staff #30 that he had heard a crack / pop when transferring the resident. Staff #46 stated that the resident is Navajo-speaking, so Staff #46 talked to the resident, who stated her leg hurt.</p> <p>A telephone call was placed to Staff #30 on April 29, 2025, at 10:05 AM, for an interview. A voicemail was left for a return call. A second call was made at 11:57 AM with no answer. The staff did not return the phone call.</p> <p>A telephonic interview was conducted on April 29, 2025, at 10:12 AM, with a CNA (Staff #91) who stated that she was aware of the incident with Resident #10, and that she was told by Staff #30 that he was transferring Resident #10 when the resident's foot caught on his foot.</p> <p>An interview was conducted with another CNA (Staff #8) on April 29, 2025, at 10:14 AM. Staff #8 stated that she was aware of the first incident with Resident #10 on March 20, 2025, because the resident stated to her that she was going to the bathroom and that two staff were assisting her and the footrest of the wheelchair hit her on the ankle area. Staff #8 stated that the resident got a boot for the ankle about a week later. After the first incident, Staff #8 stated that the Director of Rehab (DOR) provided training to the CNAs on safe transfers and ensuring the footrests were removed from the wheelchair to make sure that did not happen again. Staff #8 stated she was aware of the second incident with Resident #10 on April 12, 2025, as she was in the building on the day of the incident. Staff #8 stated that Staff #30 explained the event to herself and a nurse; and that, Staff #30 stated that he was transferring the resident, and then the resident's foot got stuck on his foot and he heard something and then went to get the nurse. Staff #8 stated that after the second incident, staff were instructed to use the hooyer lift for transferring Resident #10.</p> <p>A telephonic interview was conducted April 29, 2025, at 10:47 AM, with the resident's family and emergency contact. The family stated that approximately two weeks before the incident, where the resident's left leg was fractured, there was an incident where her right foot was injured when staff took her to the bathroom. After the first incident in the bathroom, the family stated that they had requested that two staff members be present when transferring Resident #10. Regarding the left leg injury, the family stated that a male staff member was transferring the resident, her leg got caught, and the staff, kept yanking on her, and her leg fractured in two places. The family stated that they were told by Resident #10 that she was yelling out for the male staff to slow down and stop, but he kept going. The family stated that Resident #10 stated that Staff #30 is always in a hurry, and that he does not speak Navajo.</p> <p>An interview was conducted on April 29, 2025, at 11:07 AM, with the Director of Rehab (DOR / Staff #120) who stated that Resident #10 had not received a therapy referral after the first transfer training incident on March 20, 2025. The DOR stated he has been doing transfer training with the staff, which started after the second incident on April 12, 2025. Staff #120 stated that for a squat pivot type of transfer, which is the type of transfer that was done with Resident #10, there should have been two people assisting, because of the high risk of the transfer. Staff #120 stated that the resident's injury was discussed as a clinical team and that the Director of Nursing (DON / Staff #2) and stated that the Resident #10 had been declining overall and should have been switched over to a hooyer lift transfer to increase safety.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with Resident #10 on April 29, 2025, at 11:45 AM, with a Navajo translator present. The resident stated that her leg hurt and that she remembered an incident where a man transferred her to bed and her leg popped.</p> <p>An interview was conducted with a CNA (Staff #70) on April 29, 2025, at 12:00 PM, who stated that on April 12, 2025, she was coming in for shift. She had received report that one of the CNAs was transferring the resident and that he heard her make a noise, then as he continued, he realized her leg was hurt. Staff #70 stated that she talked to Staff #30 who told her that the resident's leg got caught around the CNA's leg during the transfer. After the incident, Staff #70 stated that the facility instructed staff to only use the hooyer lift to transfer the resident and that the resident would require 2-person care moving forward.</p> <p>An interview was conducted with a registered nurse (RN/ Staff #27) on April 29, 2025, at 12:20 PM who stated that she was familiar with the incident with Resident #10 on April 12, 2025; and that, she assessed the resident approximately 5 minutes after the incident. She stated that she had observed the resident to have redness and swelling in the leg, as well as pain, and that normally, the resident does not complain of pain. Staff #27 stated that Staff #30 stated that somehow the resident's leg got wrapped up between one of the CNA's legs and he heard a pop.</p> <p>A telephonic interview was conducted with the DON (Staff #2) on April 29, 2025, at 1:54 PM. The DON stated that accident risks and hazards are identified by the facility completing a person-centered care plan, updating the residents' care plans as needed, and communicating to the CNAs. The DON stated that staff are trained to remove footrests from the wheelchair before transferring residents because there is a risk of accidentally injuring a resident's leg if caught in the foot rests during transfers. Regarding Resident #10's first incident on March 20, 2025, the DON stated that the CNA was transferring the resident and the foot rests were still on the wheelchair, the resident's foot got caught between the chair, and the foot rest and there was some bruising on the resident's ankle. The DON stated that there was no update to the resident's plan of care at that time. The CNA was educated to remove the footrests before assisting with a transfer. During the second incident on April 12, 2025, the DON stated that the CNA, Staff #30, was transferring the resident, the resident's feet did not move, and the CNA set her down and he heard a pop. The DON stated that no staff informed her that the resident's leg got caught during the transfer. The DON stated that the resident had tibia and fibula fractures in her leg. After the incident, the resident is to only have hooyer lift transfers.</p> <p>Review of the facility policy titled Resident Safety: Accidents and Incidents - Investigating and Reporting, dated January 1, 2024, revealed all accidents or incidents involving residents shall be investigated and reported to the administrator. Incident/accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities.</p> <p>Review of the facility policy titled Positioning/Moving: Safe Lifting and Movement of Residents, dated January 1, 2024, revealed in order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents. Resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. Manual lifting of residents will be eliminated when feasible. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan.</p>		