

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035094	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2024
NAME OF PROVIDER OR SUPPLIER Haven of Sedona		STREET ADDRESS, CITY, STATE, ZIP CODE 505 Jacks Canyon Road Sedona, AZ 86351	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48932</p> <p>Based off of clinical record review, staff interviews, observation of current practice, and review of the facility's policies, the facility failed to ensure residents #3, #4, and #5, were free from abuse from other residents. The deficient practice could result in residents experiencing emotional and mental trauma from the abuse.</p> <p>Related to resident #5</p> <p>Resident #5 was admitted to the facility on [DATE] with diagnoses that included Dementia, a history of strokes, and stage 3 Kidney disease.</p> <p>A review of a Quarterly MDS, dated [DATE] revealed resident #5 had a BIMS assessment completed. Resident #5 scored a 08 which indicated they were mildly cognitively impaired.</p> <p>A review of the care plan reveals it was revised on January 16, 2023 to include behavior issues as an area of focus. The care plan goals included that resident #5 would not harm themselves or others. The care plan interventions included administering medications as ordered, allowing the resident to make their own decisions about their care, anticipating and meeting their needs, remove the resident from the situation if an issue occurs, provide the resident an opportunity to make choices, and refer to a psychiatrist for consult as ordered.</p> <p>A review of resident #5's progress notes in the Electronic Health Record (EHR), reveals an entry dated August 25, 2023 at 9:08 AM. The note reveals resident #5 was not in a good mood as evidenced by them calling other people names and telling others to leave them alone.</p> <p>A second progress note, dated August 26, 2023 at 3:56 PM, reveals that a Licensed Practical Nurse (LPN) contacted the Director of Nursing (DON) to inform them that resident #5 was hit by another resident (resident #3). The progress note also indicates that a skin assessment was completed and there were no injuries.</p> <p>Review of additional Progress Notes show that alert charting was done to monitor the resident for the next two days after the incident.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of resident #5's EHR reveals that a psychiatric consult was provided on August 21, 2023 and it was recommended that resident #5 continue with their medication regimen at that time, do LABs to rule out other contributing medical conditions, and to follow up with their primary care physician.</p> <p>Related to resident #3:</p> <p>Resident #3 was admitted to the facility on [DATE] with diagnoses that included Dementia, Diabetes, and Chronic Obstructive Pulmonary Disease (COPD). Resident #3 was discharged from the facility on January 17, 2024.</p> <p>A review of the 14-day Minimum Data Set (MDS), dated [DATE] revealed resident #3 had a Brief Interview for Mental Status (BIMS) assessment completed. Resident #3 scored 03 which indicated they were severely cognitively impaired.</p> <p>A review of the care plan reveals it was revised on August 26, 2023 to include behavior issues as an area of focus. The care plan goals included that resident #3 will be able to effectively cope with his behaviors. The care plan interventions stated to administer medications as ordered ., monitor/document for side effects and effectiveness ., if issues arise, remove from situation ., intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed ., and to refer to psychiatric provider for consultation as ordered.</p> <p>A review of resident #3's Progress Notes reveals an entry dated August 24, 2023 that indicated the resident had a room change, was attempting to elope, was confused, and had a hard time finding their new room. The note also indicates that staff reoriented resident #3 to their new room throughout the shift.</p> <p>A second Progress Note entry, dated August 25, 2023, indicated resident #3 was awake most of the night.</p> <p>A review of a Behavior Note entry, dated August 26, 2023, noted that staff heard resident #3 yelling loudly in the hallway. The note indicated that staff observed resident #3 swinging arms toward resident 2 (resident #5) and making contact to back of resident 2 head, as these two resident's yelling obscenities at each other. The note also indicated that staff separated the two residents and skin assessments were conducted with no injuries noted. The note reveals that resident #3 refused to allow staff to check their vitals after the incident.</p> <p>Additional review of resident #3's Progress Notes revealed an Alert Charting note dated September 8, 2023 at 1:08 AM. The note indicated that on September 7, 2023 at 8:30 PM resident #3 was hit in their chest by resident #4. Resident #4 told staff that resident #3 would not leave them alone. The note indicates that there were no marks on resident #3's chest.</p> <p>There were no other notes in Resident #3's Progress Notes related to the September 7th incident.</p> <p>A review of the facility's records indicate that resident #3 was involved in three incidents from August through September 2023.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Related to resident #4:</p> <p>Resident #4 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease, Insomnia, and Major Depressive Disorder.</p> <p>A review of a Quarterly MDS, dated [DATE], revealed resident #4 had a BIMS assessment completed. Resident #4 scored a 07 which indicated they were severely cognitively impaired.</p> <p>A review of the care plan reveals it was revised on September 7, 2023 to include behavior issues as an area of focus. The care plan goals included that resident #4 will demonstrate effective coping of their behaviors. The care plan interventions included administering medications, anticipating the resident's needs, teaching the resident coping skills, encourage the to express their feelings, provide positive interactions, identify triggers of the behaviors, and to remove the resident from the situation if an issue occurs.</p> <p>A review of resident #4's Progress Notes revealed a note dated September 8, 2023 at 1:05 AM. The note indicated that on September 7, 2023 at 8:30 PM the staff heard resident #4 yell at another resident (resident #3) to get away. The note also indicates that staff observed resident #4 hit resident #3 in the chest. The note indicated that resident #3 told staff that resident #4 was bothering them and wouldn't leave them alone.</p> <p>Further review of the Progress Notes indicates that resident #4 was monitored for the next two days and no behaviors were noted.</p> <p>A phone call was placed to staff #4, a LPN, on May 21, 2024 at 10:40 AM to conduct an interview. It was noted in resident #5's chart that staff #4 witnessed the altercation between resident #5 and resident #3. A voicemail was left requesting staff to call the investigator back. There was no callback prior to the end of the investigation.</p> <p>A phone call was placed to staff #6, a LPN, on May 21, 2024 at 10:54 AM to conduct an interview. A voicemail was unable to be left as the voicemail inbox was full.</p> <p>An interview was conducted on May 21, 2024 with a Certified Nursing Assistant (CNA/Staff #2). Staff #2 indicated that the facility provides training to staff throughout the year related to abuse. Staff # 2 indicated that when there is a resident-to-resident abuse, they have been trained to redirect the residents and provide 1:1 staffing to monitor. Staff #2 indicated that they typically care for approximately 11 residents during their shift.</p> <p>An interview was conducted on May 21, 2024 at 8:32 AM with staff #3 (CNA). Staff indicated they care for around 15 residents during a shift. When asked how the facility ensures residents are safe from other residents, staff #3 indicated that they monitor their behaviors. They know who are prone to altercations and will monitor those residents more closely. Staff also indicate that they are aware of specific residents that do not get along with other residents and will monitor those situations as well.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the Director of Nursing (DON/Staff #1) on May 21, 2024. Staff #1 indicated that all residents were care planned for their behaviors and the facility had the appropriate interventions in place. They indicated that the facility was taking all of the appropriate measures to ensure the safety of the residents.</p> <p>A review of the facility's policy, titled Resident Rights/Dignity: Abuse and Neglect - Clinical Protocol indicates that it was last reviewed on January 1, 2024. The policy defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48932</p> <p>Based on clinical record review, staff interviews, and policy review, the facility failed to ensure there was sufficient staffing to provide quality resident care. The deficient practice could result in residents' care needs not being met.</p> <p>Findings include:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses that included a fracture of the left femur, Chronic Obstructive Pulmonary Disease (COPD), and Anxiety disorder.</p> <p>The 5-day Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. The MDS also indicated resident #1 needed partial/moderate staff assistance for moving from a laying in the bed position to sitting on the side of the bed position. It also indicated that the ability to get on and off the toilet was not assessed due to a medical condition or safety concern.</p> <p>The facility's staff schedule was reviewed for Thursday, May 2, 2024 and Friday, May 3, 2024.</p> <p>Thursday May 2, 2024 had the following staff:</p> <p>Day shift</p> <ul style="list-style-type: none"> -4 Certified Nursing Assistants (CNA) -1 Certified Medical Assistant (CMA) - 2 Licensed Practical Nurses (LPN) <p>Night shift</p> <ul style="list-style-type: none"> -1 CNA -1 Registered Nurse (RN) <p>Friday May 3, 2024 had the following staff:</p> <p>Day shift</p> <ul style="list-style-type: none"> -2 CNAs -1 CMA -2 LPN <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Night shift</p> <p>-2 CNAs</p> <p>-1 LPN</p> <p>-1 RN</p> <p>Review of the facility assessment, dated March 21, 2024, reveals that the facility had determined it needed 3 - 4 CNAs working the night shift in order to meet resident needs.</p> <p>A call was placed to a RN (Staff #5) on May 21, 2024 at 8:02 AM. This staff worked the night shift on May 2nd . A voicemail was left and was not returned prior to the conclusion of the investigation.</p> <p>A call was placed, two times, to a CNA (Staff #7) on May 21, 2024 at 8:05 AM. Both times the call did not go through. This staff worked the night shift on May 2nd.</p> <p>An interview was conducted on May 20, 2024 with the Director of Nursing (DON/Staff #1) at 2:40 PM. Staff #1 stated that a second CNA had been scheduled to work the night shift on May 2, 2024 but had called off. Staff #1 indicated that they had ended up working that shift so there was a total of three staff members working the night shift on May 2nd. Staff #1 stated that resident #1 was upset that night because between the three of them that were working, they were not able to be as attentive as the resident wanted. Staff #1 also indicated that resident #1 did not make any complaints about the care she received that night until the next day. Staff stated that resident #1 had told them that staff #5 had been rough with them because they had moved the resident too quickly. The resident then complained of hip pain and was sent to the hospital immediately. The resident never returned.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48932</p> <p>Based on clinical record review, staff interviews, and policy review, the facility failed to ensure one resident (#1) was administered pain medications as ordered. The deficient practice resulted in a resident experiencing unnecessary pain.</p> <p>Findings include:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses that included a fracture of the left femur, Chronic Obstructive Pulmonary Disease (COPD), and Anxiety disorder.</p> <p>The 5-day Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.</p> <p>Review of the physician's orders dated April 26, 2024 included Hydrocodone-Acetaminophen (an analgesic opioid) Oral 5-325 milligram (mg) tablet every 4 hours as needed for pain 6-10. A second order was revealed for Acetaminophen 325 mg two tablets every 4 hours as needed for pain 1-5.</p> <p>Review of resident #1's care plan, initiated April 26, 2024, revealed the resident was at risk for pain. Interventions included to administer analgesia medications as ordered.</p> <p>A review of the April 2024 Medication Administration Record (MAR) indicates on April 26 and April 27 resident #1 had pain rated at an 8 and was administered Acetaminophen 325mg.</p> <p>Review of the clinical record reveals no evidence of the resident's pain levels in the progress notes for April 26, 2024.</p> <p>Review of the clinical record reveals a progress note dated April 27, 2024 at 12:49 PM. The note indicated that Hydrocodone-Acetaminophen 5-325mg was administered. There are no notes documenting the pain level. This note does not match what was documented on the MAR for April 27, 2024.</p> <p>A call was placed to a Registered Nurse (RN/Staff #5) on May 21, 2024 at 8:02 AM who was the staff who administered pain medications outside of the established parameters. A voicemail was left and was not returned prior to the conclusion of the investigation.</p> <p>An interview was conducted with the Director of Nursing (DON/Staff #1) on May 20, 2024 at 2:40 PM. Staff #1 indicated that resident #1 was a late admit on Friday, April 26, 2024. Staff #1 indicated that the staff working the floor did not have access to a new medication supply cart called Subix which is stored in the Medication room. Because of this, staff were not able to access the Hydrocodone-Acetaminophen at the time the resident requested it. Staff #1 stated they came into the facility on [DATE] to assist staff with access to Subix. Staff #1 stated that they started using Subix on May 1st and some staff were having troubles accessing it. Surveyor reminded staff #1 that the medication concern in question took place on April 26 and April 27, 2024 which was before the switch took place. Staff #1 was not able to explain why medication parameters were not followed and why staff #5 did not have access to the medication supply cart.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When asked what their expectation was related to administering pain medications, Staff #1 indicated that staff are to follow the pain scale and administer pain medications according to the resident's pain level according to physician's orders. Staff #1 stated that they have a flyer at each nurses' station that outlines the steps nurses are to take if medications are not available. When asked what would be the risks associated with not following physician's orders related to pain medications, Staff #1 stated that the resident's pain is not targeted and relief is not provided. Staff #1 acknowledged that resident #1 did have their pain treated appropriately that night (April 26 and April 27).</p> <p>A review of the facility policy titled, Pain Management: Administering Pain Medications, revealed the facility will administer pain medications as ordered.</p>		