

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Haven of Sandpointe, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2222 South Avenue A Yuma, AZ 85364	

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** 42319</p> <p>Based on staff interviews, clinical record review, facility documents and facility policy, the facility failed to ensure a resident was free from abuse. This deficient practice could result in further incidents of physical abuse.</p> <p>Findings include:</p> <p>Resident #21 was admitted on [DATE] with diagnoses of anxiety disorder, and depression.</p> <p>A quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had a BIMS (Brief interview for mental status) of 2, indicating that this resident was severely cognitively impaired and included inattention and disorganized thinking continuously present.</p> <p>A care plan dated April 15, 2024 included this resident had a behavior problem including impaired cognitive function, impaired safety awareness, wandering/exit-seeking, threatening, throwing water cups to staff despite staff reorientation/education and resident to resident altercation despite staff redirection with interventions. Interventions including intervene as necessary to protect the rights and safety of others. These interventions note a revision on November 25, 2024, however the revisions noted to the care plan do not include any changes or new interventions. No new interventions were added to this focus since April 15, 2024</p> <p>A progress note dated July 13, 2024 at 6:01 p.m. included that the nurse writer witnessed an altercation between resident and another patient. This note included that a male resident sat down at a dining table and this resident started cursing at the other resident and lunged towards him. This note included that a CNA stopped resident this from making contact and that the male resident was escorted to another table . However, no new interventions were added to the care plan for this interaction and review of the tracking system did not find that this incident was reported.</p> <p>A progress note dated July 27, 2024 included Resident is aggressive towards other residents and staff; throw objects across table; difficulty redirecting. Will continue to monitor However, no new interventions were added to the care plan for this interaction and review of the tracking system did not find that this incident was reported.</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>A progress note dated September 4, 2024 included at 3:30 p.m. (resident #21) was choking (resident #6) and that a CNA noticed and stopped her. This note included that (resident #21) said she was just playing and that no injuries noted on (resident #6). (Resident #6) stayed in the dining area and (resident #21) went to her room right after.</p> <p>A progress note dated November 18, 2024 at 7:50 p.m. included that Resident was upset due to another resident letting staff know that resident spit her pills out when staff turned away and that this resident got upset and threw plastic cup at the other resident. This note included that this resident attempted to kick resident and that she was redirected. However, no new interventions were added to the care plan for this interaction and review of the tracking system did not find that this incident was reported.</p> <p>-Resident #6 was admitted on [DATE] with diagnoses of dementia and anxiety.</p> <p>A quarterly MDS dated [DATE] revealed the resident had a BIMS of 3, indicating the resident was severely cognitively impaired with inattention and disorganized thinking continuously present.</p> <p>A care plan dated April 19, 2024 included that the resident has a behavior problem related to verbal behavior, wandering and unaware of safety precautions. This focus has an intervention to intervene as necessary to protect the rights and safety of others, and to remove from situation and take to alternate location as needed. This focus has no new interventions after May 10, 2024.</p> <p>A progress note dated November 24, 2024 included, Around 1930 nurse hear CNAs assisting resident and trying to get resident out of her room. At arrival (resident #21) was very agitated and screaming at CNAs. CNAs were trying to get (resident #6) out of room, CNA and nurse stayed with (resident #21) while other CNA help (resident #6) get out of room through the next room's shared bathroom, because (resident #21) was blocking the door. CNAs and nurse were able to separate residents and keep both safe. CNAs reported they witnessed resident walking and (resident #21) getting up from her bed. When resident was going back to her bed, resident pulled on her roommate's oxygen tubing, then (resident #21) grabbed resident's hair and pushing her away. CNA told roommate to let her go and roommate did. Both residents were separated for their safety. A full skin assessment was done to both residents. No injuries or open areas noted on either resident .</p> <p>An interview conducted on November 26, 2024 with a Registered Nurse (RN/staff #54) who said that she is the regular nurse for this hall. She said that resident #21 and resident #6 are sisters and that resident #21 can get aggressive at times and that she is upset by others in the chair she likes to sit in in the common area and that there was a male resident that she did not like. She said that resident #21 tried to kick a male resident when he was in her chair and also when he told a nurse that resident #21 did not take her medication. She said that she was informed that resident #21 had pulled someone's hair but that she had not yet reviewed the notes. She said that resident can't be in with her sister but can't be without her. She said that resident #21 tries to defend resident #6 from other residents and that resident #21 had tried to smack resident #6 before. She said that if no staff intervenes she could see resident #21 hurting another resident. She said that they had tried to move resident #21 and 6 to different rooms in the past but that the resident's guardian did not agree. She said that staff have to alternate on their jobs because they cannot take their eyes off of the residents or an incident would occur. This nurse said that the if it is needed that staff #32 and #71 will make changes to the care plan if it's needed and that it might be needed for resident #21.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on November 26, 2024 at 12:44 p.m. with a Certified Medication Assistant (CMA/staff# 37) who said that resident #21 is quiet but when we don't understand what she wants she gets mad, doesn't want anyone in her chair. This staff said that if a resident sits in her chair she gets mad and kicks and throws water. This staff said that resident #21 does not want resident #6 to get up and down. This staff said that they were told that over the weekend that resident #21 and resident #6 had fought and that the resident's representative wanted them in the same room. This staff said that this was not the first time that these two residents had fought. This CMA said that resident #21 had gotten angry at another resident who had said that resident #21 had not taken her medication so when that staff asked her to open her hand, she got mad at the resident and threw the cup of water. This staff said that the staff asked resident #21 to go and apologize after she had calmed down, and that resident #21 came back and kicked the resident.</p> <p>An interview was conducted on November 26, 2024 at 12:28 p.m. with a Certified Nursing Assistant (CNA/staff #17) who said that this is the primary hall they work on. This staff said that resident #21 and resident #6 get along at times and that resident #21 wants to have control over #6's wandering. This staff said that resident #6 is unaware and just wanders. This staff said that resident #21 had tried to strangle resident #6 in the past and that usually if they go after another we try to separate them or stop that from getting out of hand. This staff said that there are interventions that the staff usually uses such as placing them at different tables and currently separating these residents but that they do not think that there are interventions on the care plan.</p> <p>An interview was conducted on December 5, 2024 at 12:31 p.m. with a CMA (staff #14) who said that they are a Medication Technician and that they work CNA shifts as well. This staff said that resident #21's triggers are if she sees residents arguing or if they are loud or if someone being mean to her sister, or if she goes to sleep and resident #6 is up and wandering it bothers her. This staff stated that was there when resident #21 pulled resident #6's hair. She said that she was finishing up care in the room and resident #21 was at the door and resident #6 was behind her trying to get out. She said that resident #21 was mad and just wanted her (#6) to get out. This staff said that she called the other CNA and that resident #21 was wearing her oxygen and that the tubing was going around the bed, so she told resident #21 that resident #6 would trip and then resident #6 wandered back to bed and got tangled with the oxygen tubing and pulled on it. Resident #21 turned around and grabbed resident #6 and was shaking her and shoved her to the foot of the bed and she bounced off of it and got scared. This staff said that she and the CNAs were telling resident #21 to be nice don't do that and the nurse got in front of her and told her to stop hurting her sister. This CNA said that resident #21 got upset that she was trying to get resident #6 out and that the nurse was distracting and calming her down, so she opened the bathroom where resident #6 was trying to hide and she helped her out the bathroom door to the adjoining room and kept her with us in the dining room through the ending of the shift. This CNA said that she was not on shift for the strangling though she had heard about it. She said that the staff do follow the care plan but also they try to ask the other CNAs to see what will help and tell each other that they have doing this to help that situation out. This CNA said that they get abuse training every month, mostly online and sometime in person. She said that she reports it to the nurse so that the nurse can take action and report it.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on December 23, 2024 at 2:04 p.m. with the Director of Nursing (DON/staff #43) who said that abuse is anything that can harm the residents and that abuse could be physical, or emotional. This DON said that someone who is not cognitively intact can abuse another person and that they care plan abuse. This staff said that usually the staff would care plan under the initiator and include any trigger that may have caused that, anything that would help the staff to recognize coming behaviors. This DON stated that the care plan was revised on November 25th but did not provide an answer as to why there was not a new intervention. She stated that any care plan revisions would be on the care plan and not documented elsewhere. This DON stated that that the staff report abuse immediately within the 2 hour window. She said that she did not know about the other issues of abuse that were noted in resident #21's clinical record.</p> <p>A policy titled Resident Rights/Dignity: Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated January 1, 2024 revealed that residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation and that this includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. This document includes that this facility will investigate and report any allegations within timeframes required by federal requirements.</p> <p>A policy titled Assessments/Care Planning: Care Plans, Comprehensive Person-Centered revealed that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. This document included that services provided for or arranged by the facility and outlined in the comprehensive care plan are trauma-informed and that assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.</p>		