

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/01/2024
NAME OF PROVIDER OR SUPPLIER Havasu Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3576 Kearsage Drive Lake Havasu City, AZ 86406	

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 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>48812</p> <p>Based on review of the clinical record, facility documentation, staff interviews, and policy, the facility failed to ensure residents property is not misappropriated.</p> <p>Findings include:</p> <p>On March 31, 2023 the facility became aware that the residents Petty Cash box was missing \$110.00. It appeared that the money went missing between April 1, 2023, and April 14, 2023.</p> <p>An interview was conducted on January 30, 2024, at 12:20 pm with the Administrator (Staff #38) in regard to the incident. Staff #38 was asked who had access to the resident cash account to which he replied the only individuals that had access to the money were the Office Manager (Staff #63), Accounts Receivable (Staff #32), and the Receptionist at the time (Staff #100).</p> <p>Staff #38 was asked if a facility investigation had been conducted in regard to the matter; Staff #38 stated that an internal investigation was conducted into the incident, which included going over the account logs and interviewing the staff with access to the funds.</p> <p>Staff #38 stated that at no time were any individuals who had access to the petty cash box placed on leave pending the investigation, nor was there any additional audit conducted to ensure that other money was not missing. After interviews with staff, the only conclusion that was made was that the money went missing with no account as to where or why.</p> <p>Staff #38 stated that On April 19, 2023, Staff #100 was interviewed; until this date, Staff #100 worked April 3, 2023, through April 6, 2023, and then was out sick from April 7, 2023, through April 14, 2023. During the interview, an admission of improper accounting regarding the incident was made by Staff#100, and her employment was immediately terminated.</p> <p>When asked if the incident had been reported to the applicable agencies as per the facility policy and state and federal regulations, Staff #38 stated, No.</p> <p>When asked why this had not been reported, Staff #38 stated that he chose to report it only to his regional operations consultant. Staff #38 was additionally asked if he was familiar with the facility policy in regards to reporting incidents in the facility as well as the state and federal regulations, to which he replied, Yes.</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 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 January 30, 2024, at 12:50 pm with Staff #63 in regard to the incident. When asked, Staff #63 stated that she did recall the incident and that money was missing from the resident cash fund. She stated that the only individuals who have access to this fund at the time besides her where Staff #32 and Staff #100. She stated that while she had access to the funds, handling them was not a normal task of hers and she only did it when the other staff members were unavailable.</p> <p>She stated that she was interviewed by Staff #38 in regards to the incident but was never put on leave pending the disposition of the investigation. To her recollection the money was never found.</p> <p>An interview was conducted on January 30, 2024, at 12:50 pm with Staff #63 in regard to the incident. She stated that she was the one that discovered the missing funds, it was after she had attempted to reconcile the residents petty cash fund that she found that it was missing \$110.00.</p> <p>Staff #63 stated that the process of petty cash is that the facility keeps \$300.00 in cash and that the residents who need cash can get it from the petty cash fund and then the funds are taken or reconciled from the residents account. She stated that she was interviewed by Staff #38 in regards to the incident but was never put on leave pending the disposition of the investigation.</p> <p>Staff #63 stated that during the investigation and through a process of elimination it was determined that could not have been anyone other than Staff#100, and when interviewed about the incident did not at anytime deny that she had taken the money.</p> <p>Per the facilities policy titled Abuse Prevention Program revised September 2021 it defines Misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful, temporary or permanent used of a resident's belongings or money without the resident's consent.</p> <p>The policy states that if an incident occurs, or there is any allegation that an incident might have occurred, of abuse, neglect, mistreatment, or misappropriation of resident property, the administrator, or designee will investigate. Furthermore, while the investigation is being conducted, accused individuals or those suspected of being responsible for abuse, neglect, mistreatment, or misappropriation of resident property and are employees of the facility will be placed on suspension pending the results of the investigation.</p> <p>The policy further states that when an alleged violation involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately. The local police or sheriff is to be notified when items of a \$25.00 or greater value are taken from a resident by an identified staff person.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>48812</p> <p>Based on review of the clinical record, facility documentation, staff interviews, and policy, the facility failed to ensure residents property is not misappropriated.</p> <p>Findings include:</p> <p>On March 31, 2023 the facility became aware that the resident's Petty Cash box was missing \$110.00. It appeared that the money went missing between April 1, 2023, and April 14, 2023.</p> <p>An interview was conducted on January 30, 2024, at 12:20 PM with the Administrator (Staff #38) in regard to the incident. Staff #38 was asked who had access to the resident cash account to which he replied the only individuals that had access to the money were the Office Manager (Staff #63), Accounts Receivable (Staff #32), and the Receptionist at the time (Staff #100).</p> <p>Staff #38 was asked if a facility investigation had been conducted in regard to the matter; Staff #38 stated that an internal investigation was conducted into the incident, which included going over the account logs and interviewing the staff with access to the funds.</p> <p>Staff #38 stated that at no time were any individuals who had access to the petty cash box placed on leave pending the investigation, nor was there any additional audit conducted to ensure that other money was not missing. After interviews with staff, the only conclusion that was made was that the money went missing with no account as to where or why.</p> <p>Staff #38 stated that On April 19, 2023, Staff #100 was interviewed; until this date, Staff #100 worked April 3, 2023, through April 6, 2023, and then was out sick from April 7, 2023, through April 14, 2023. During the interview, an admission of improper accounting regarding the incident was made by Staff#100, and her employment was immediately terminated.</p> <p>When asked if the incident had been reported to the applicable agencies as per the facility policy and state and federal regulations, Staff #38 stated, No.</p> <p>When asked why this had not been reported, Staff #38 stated that he chose to report it only to his regional operations consultant. Staff #38 was additionally asked if he was familiar with the facility policy in regards to reporting incidents in the facility as well as the state and federal regulations, to which he replied, Yes.</p> <p>An interview was conducted on January 30, 2024, at 12:50 PM with Staff #63 in regard to the incident. When asked, Staff #63 stated that she did recall the incident and that money was missing from the resident cash fund. She stated that the only individuals who have access to this fund at the time besides her were Staff #32 and Staff #100. She stated that while she had access to the funds, handling them was not a normal task of hers and she only did it when the other staff members were unavailable. She stated that she was interviewed by Staff #38 in regards to the incident but was never put on leave pending the disposition of the investigation. To her recollection the money was never found.</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 - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>48812</p> <p>Based on review of the clinical record, facility documentation, staff interviews, and policy, the facility failed to ensure residents property is not misappropriated.</p> <p>Findings include:</p> <p>On March 31, 2023 the facility became aware that the residents Petty Cash box was missing \$110.00. It appeared that the money went missing between April 1, 2023, and April 14, 2023.</p> <p>An interview was conducted on January 30, 2024, at 12:20 PM with the Administrator (Staff #38) in regard to the incident. Staff #38 was asked who had access to the resident cash account to which he replied the only individuals that had access to the money were the Office Manager (Staff #63), Accounts Receivable (Staff #32), and the Receptionist at the time (Staff #100).</p> <p>Staff #38 was asked if a facility investigation had been conducted in regard to the matter; Staff #38 stated that an internal investigation was conducted into the incident, which included going over the account logs and interviewing the staff with access to the funds.</p> <p>Staff #38 stated that at no time were any individuals who had access to the petty cash box placed on leave pending the investigation, nor was there any additional audit conducted to ensure that other money was not missing. After interviews with staff, the only conclusion that was made was that the money went missing with no account as to where or why.</p> <p>Staff #38 stated that On April 19, 2023, Staff #100 was interviewed; until this date, Staff #100 worked April 3, 2023, through April 6, 2023, and then was out sick from April 7, 2023, through April 14, 2023. During the interview, an admission of improper accounting regarding the incident was made by Staff#100, and her employment was immediately terminated.</p> <p>When asked if the incident had been reported to the applicable agencies as per the facility policy and state and federal regulations, Staff #38 stated, No.</p> <p>When asked why this had not been reported, Staff #38 stated that he chose to report it only to his regional operations consultant. Staff #38 was additionally asked if he was familiar with the facility policy in regards to reporting incidents in the facility as well as the state and federal regulations, to which he replied, Yes.</p> <p>An interview was conducted on January 30, 2024, at 12:50 PM with Staff #63 in regard to the incident. When asked, Staff #63 stated that she did recall the incident and that money was missing from the resident cash fund. She stated that the only individuals who have access to this fund at the time besides her where Staff #32 and Staff #100. She stated that while she had access to the funds, handling them was not a normal task of hers and she only did it when the other staff members were unavailable. She stated that she was interviewed by Staff #38 in regards to the incident but was never put on leave pending the disposition of the investigation. To her recollection the money was never found.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48087</p> <p>Based on clinical record review, staff interviews, and policy review, the facility failed to ensure the appropriate services for mental or psychological difficulty was provided for one resident (#6). The deficient practice could lead to the resident not receiving the behavioral healthcare services needed.</p> <p>Findings include:</p> <p>Resident #6 was admitted to the facility on [DATE] with diagnosis of depressive episodes, type 2 diabetes, and hypertension.</p> <p>Review of the nursing note dated 6/22/2023 identified that the resident was talking in a loud voice and being argumentative with a Certified Nursing Assistant (CNA) in the dining room.</p> <p>A care conference note dated on 5/31/2023 at 10:45 AM revealed that resident #6 is smearing his stool on the curtain, the resident's bed, and himself. The care conference note revealed that resident #6 is declining to allow staff to assist in cleaning him up; this is a long-standing behavior that increases at times.</p> <p>A Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact.</p> <p>Review of a care conference conducted on 11/21/2023 at 10:30 AM revealed that resident #6 was told multiple times to make sure his body is covered up while laying in bed or close the curtain. The care conference stated that resident #6 likes to lay in bed without clothes on at times.</p> <p>Review of the encounter note titled BHS Psych - Follow up on 01/17/2024 at 9:30 AM indicated the resident was being seen for a psychiatric reassessment for previous major depressive disorder (MDD). The encounter note indicated that the resident mood is 8 and symptoms of depression were denied during the psych visit. However, upon revealing the encounter note, it did not show that the resident behaviors of yelling and being argumentative with staff was addressed. In addition, the encounter note also did not address the resident behaviors of playing with his own feces and smearing it on his bed, curtain, and body.</p> <p>An interview was conducted on 01/31/2024 at 9:35 AM with a Licensed Practical Nurse (LPN/Staff #52) stated this resident has a wide variety of certain behaviors. He does not really participate in activities, lacks social skills, and has inappropriate behaviors with other residents and staff at times. Staff #52 also stated we would catch the resident playing with his feces and urine a couple times a week. Staff #52 states the resident would not utilize his call lights when he needs help and would smear his feces in his body, curtains, and bed. When asked if resident #6 was referred for an updated Preadmission Screening and Resident Review (PASRR) Level II, staff #52 stated she is not aware of it and it is not within her scope of practice to refer for a PASRR Level II.</p> <p>(continued on next page)</p>		

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<p>F 0740</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/Staff #69 on 01/31/24 at 12:15 PM revealed relayed that resident #6's PASRR was not filled out completely as it did not address the resident Scatolia behaviors and certain areas that asked if the resident has issues with the adaptation of change, interpersonal symptoms, and concentration/related tasks symptoms. Staff #69 stated the resident behaviors of playing with his own feces were already notified to the Psych provider. However, upon reviewing the psych provider notes dated 8/8/23, 11/15/23, 1/1/24, and 1/21/24, did not indicate the resident Scatolia behaviors were informed or reviewed by the psych provider.</p> <p>Review of the facility policy, Behavior Monitoring under the Abuse Prevention program reviewed and revised on 09/2021 stated the facility will provide appropriate treatment and services to a resident who displays mental or psychological adjustment difficulty, in order to correct the assessed problem or provide care that is appropriate to that problem. The goal will be to assist the resident to reach and maintain his or her highest level of mental health and psychosocial functioning. For a resident who is exhibiting difficulties in the area, the staff should assure that there is an assessment of the residents' .when indicated, a psychological or psychiatric evaluation to assess, diagnose, and treat the condition should be completed.</p>		