STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035100	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havasu Nursing Center	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)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, staff interviews, and review of facility policy, the facility failed to ensure that transfer/discharge notifications were made for three sampled residents (#2), (#4) and (#6) to the representative of the Office of the State Long-Term Care Ombudsman. The deficient practice can result in further notifications of resident transfer/discharge not being provided to the Ombudsman.Findings include:-Resident #2 was admitted to the facility June 9, 2025 and discharged [DATE] with diagnoses that included encounter for other orthopedic aftercare, other specified degenerative diseases of basal ganglia, nontraumatic intracranial hemorrhage, unspecified, need for assistance with personal care.A discharge Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident had an unplanned discharge home with hospice. A Brief Interview for Mental Status (BIMS) was conducted revealing a score of 07, indicating severe cognitive impairment. Further review of the MDS revealed no indicators for mood or behaviors and that the resident required partial to moderate assistance with activities of daily living. Review of the Order Summary Report did not reveal an order for the resident to be discharged home with hospice services.However, review of the resident's Census List indicated that the resident discharged on June 13, 2025. A progress note dated June 13, 2025 documented that the, residents family advised that transport was coming to pick up resident to take home. Family advised resident is now a patient of hospice. AMA form was explained to family, and family was educated about taking patient AMA. See chart for signed AMA form. Resident left at approx. 1141 via wheelchair.-Resident #4 was admitted to the facility July 10, 2025 and discharged (AMA) July 11, 2025 with diagnosis including aftercare following joint replacement surgery, chronic obstructive pulmonary disease, unspecified, need for assistance with personal care. Review of the MDS assessment dated [DATE] revealed BIMS for resident #4 was unavailable for review. Further review revealed no indicators for behaviors, required supervision to moderate assistance with ADL's with a recent hip and knee replacement. Review of the care plan conference summary dated July 11, 2025 documented Resident concerned about staying at the facility due to husband's pancreatic cancer, Parkinson's and chemo fog. Resident insisted on going home to be with her husband and agreed to sign the AMA paperwork-Resident left the facility before signing the AMA document.A progress note dated July 11, 2025 documented resident left AMA.-Resident #6 was admitted to the facility July 18, 2025 and discharged AMA August 14, 2025 with diagnosis including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, acute kidney failure, unspecified, unspecified abnormalities of gait and mobility, unsteadiness on feet. Review of the care plan date-initiated June 24, 2025 revealed a focus for discharge planning. Interventions included determine resident/representative goals for discharge.Review of the MDS assessment dated [DATE] revealed a BIMS of 15, indicating resident's cognition intact. There were no indicators for mood or behaviors and requires substantial to maximum assistance with ADL's.A progress note dated August 15, 2025 documented resident left the facility AMA and that the provider was made aware. Review of an Against Medical Advice Discharge Form dated August 14, 2025 was signed by resident #6 and Licensed Practical Nurse (Staff/LPN #62).A written request was submitted to the facility on September 4, 2025 at 1:47 pm requesting Ombudsman notification for June, July and August 2025.An interview was conducted on September 4, 2025 at 4:00 pm with the Administrator (Staff #23) and Director of Nursing (DON/Staff #19). It was stated when there is a resident who discharges from the facility AMA the facility will try to find out the need for discharge, ensure the resident is safe and provide notification of the AMA to all responsible parties. It was stated social services was responsible for notifying the ombudsman of all resident discharges, including those residents who discharge AMA. It was stated social services quit without notice, leaving administration to divide social service responsibilities among staff. Staff #23 stated he was responsible for notifying the state ombudsman and there was no documentation to provided that the state ombudsman was notified of AMA discharges. Review of the facility policy titled Discharging a Resident Without a Physician's Approval Revision date: March 2025 states a physician's or providers order is obtained for discharges, unless a resident or representative request the discharge against medical advice.Review of the facility policy titled Transfer or Discharge states Once admitted to the facility, residents have the right to remain in the facility. Transfers and discharges must meet specific criteria and require resident/representative notification, orientation, and documentation in the medical record.