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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havasu Nursing Center	3576 Kearsage Drive Lake Havasu City, AZ 86406

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on clinical record review, staff and family interviews, and facility documents and policy, the facility failed to ensure a resident's privacy was maintained during medication administration for one resident (resident #27). This deficient practice could result in further violations of resident privacy. Findings include: An observation was made on April 9, 2025 at 07:51 a.m. Licensed Practical Nurse (LPN) Staff #23 prepared medications for Resident #27. Staff #23 stepped away from the medication cart and went into Resident #27's room and gave the medications, however the computer screen was not closed or locked, displaying Resident #27's name, date of birth and medications. Staff #23 came back to screen and utilized the computer then turned around and went back into Resident #27's room again. The screen still had resident #27's name up with the screen unlocked. At 7:58 a.m. Staff #23 came back to the cart and was shown the screen and asked what could happen if the computer was left unlocked and unattended? Staff #23 stated somebody could come and mess with it. An interview was conducted on April 10, 2025 at 10:49 a.m. with Director of Nursing (DON) Staff #27 and revealed that the process for the medication pass and screen access is to either minimize or close the screen from any resident information display. Staff #27 state that if the screen was already left unlocked someone could see something that is HIPPAA (Health Insurance Portability and Accountability Act) protected. Asked how important is it to lock the screens and Staff #27 stated that it is absolutely important, everybody knows how important it is to protect the information. A review of the Resident Rights policy (revised February 2021), revealed that the Policy Statement reads: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: section t. Privacy and confidentiality. A review of the HIPAA Training Program policy (revision date April 2007) revealed that under the Policy Interpretation and Implementation part 1. To ensure the confidentiality of out resident's protected health information (PHI) and facility information, a HIPAA and data security training program will be provided for all employees and business associates who have access to protected health and facility information.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews and policies and procedures, the facility failed to ensure that a centered care plan with interventions was developed for one resident (#15) with oxygen orders. The deficient practice could result in a care plan that is not person centered. Findings include: Resident #15 was admitted on [DATE], with diagnosis included hemiplegia and hemiparesis, Type 2 diabetes mellitus, hypothyroidism, and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief interview Mental Status (BIMS) of 08 which indicated the resident was cognitively impaired. Review of Initial Care plan dated September 20, 2022 revealed no focus area for oxygen. A review of the documented physician order revealed oxygen at 2 liter via nasal cannula to keep oxygen levels at 90 or above with start date of March 24, 2025. Review of a health status provider note dated March 30, 2025 revealed a verbalized understanding and discussed patient decline and use of oxygen as patient is needing the oxygen to keep oxygen saturations above 90%. A physician order dated April 10, 2025 revealed that resident #15 was on continuous supplemental oxygen at 2 liter per minute, via nasal cannula to maintain oxygen saturation above 90%. However, review of the compressive care plan revealed no focused area for oxygen. An interview was conducted on April 09, 2025 at 08:48AM with Certified Nurse Assistant (CNA/staff #18), who stated that staff know who is on oxygen through the nursing reports or when the resident is admitted . Staff #18 stated that the nursing report will provide information regarding how many liters as well as which machine is used for a resident. Staff #18 stated that she was aware of resident #15 being on oxygen. Staff #18 stated that the CNA, Registered nurse, social workers, and resident coordinators help in creating the care plans for the residents. The oxygen should be care planned for the resident; and that, the risks is that their oxygen saturation can drop. An interview was conducted on April 09, 2025 at 10:24AM with Licensed Practical Nurse (LPN/Staff #23), who described the facility process for oxygen administration who stated that it was importantant that oxygen is properly connected and resident is getting adequate amounts of oxygen liter. Staff #23 stated that resident #15 had been declining and was on oxygen at 2 liters and her oxygen saturations are monitored throughout the day. Staff #23 stated that the oxygen is care planned, but was unable to locate it on care plan. She confirmed that it should have been care planned. Staff #23 stated the MDS coordinator does the care planning; but that, all staff assigned to the resident are responsible for it. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on April 09, 2025 at 10:38AM with Minimum Data Set (MDS) Coordinator (Staff #43), who confirmed that she participates in the care planning and reviews doctors ' orders then creates care plans. Staff #43 stated that if doctor had oxygen order she would add it to the care plan and nurse will do it as well. Staff #43 stated that she had been into resident #15 room, but could nott recall if the resident was on oxygen. She reviewed residents #15 order and confirmed that she did not care plan for oxygen. MDS coordinator stated that if oxygen is not care planned the resident will be at risk of respiratory failure. An interview was conducted on April 10, 2025 at 01:08PM with Director of Nursing (DON/staff #27), who stated that the facility expectation is to have oxygen care planned so that nurses can implement orders. Staff #27 stated that risks when oxygen administration are not care planned is that oxygen will not be delivered effectively such as possibly not getting tubing changed when it supposed to be. Further, staff #27 stated that staff members would not know if the resident needs oxygen and how much is needed. A review of policy titled Oxygen Administration revealed that review of the resident ' s care plan to asses for any special needs of the resident. A review of policy titled care plan revealed that care plan should focus on the course of action needed to attain or maintain highest practicable level of well-being, based on communication about reliable, consistent and understood by all team members.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy and procedures, the facility failed to ensure that the care plan was revised after each fall for one (#94) of four sampled residents. The deficient practice could result in resident not getting the individualized care that they need. Findings include: Resident #94 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, muscle weakness, unsteady on feet, abnormality of gait and mobility. An admission fall risk evaluation dated March 27, 2025 revealed that the resident had a history of 1-2 falls in the last 3 months. Further review of fall risk evaluation revealed that the resident was alert and oriented x 3. A care plan initiated on March 28, 2025 revealed that the resident had the high risk for falls. Interventions included to anticipate needs; ensure call light is within reach when in room; to participate in activities that promote exercise, physical activity for strengthening and improved mobility and ensure use of non-skid socks when ambulating or mobilizing in wheelchair. Further review of care plan revealed that the resident needed assistance with activity of daily living (ADL) tasks. An admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated that the resident is cognitively intact. Further review of the MDS dated [DATE], revealed that the resident had two falls in the last six months prior to admission. A progress note dated April 7, 2025 revealed that the resident was observed by staff sitting on floor next to her bed. According to the note the resident stated that she lost her balance, slid to floor and denied any head injuries. Doctor and family were notified. However, there was no evidence in the clinical record that the care plan had been revised regarding the fall on April 7, 2025; and that, a fall incident report had been initiated. A progress note dated April 8, 2025 revealed that Resident #94 was observed by the nurse lying on the floor in her room in front of the bathroom door. The note indicated that the resident had green/purple bruising on her right ankle/foot. The progress further revealed that the resident had a pain level of eight out of ten and was sent to emergency room (ER) for evaluation and treatment. A progress note dated April 8, 2025 at 2:59 p.m. by Licensed Practical Nurse (LPN/ staff # 13) regarding post fall revealed that the resident had an acute facture of the right 4th rib with 1-2-millimeter (mm) displacement with mild swelling around rib and the doctor and family were notified. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A fall incident report dated April 8, 2025, revealed that the resident sustained a fall with contributing factors listed as wet floor, weakness/fainted, ambulating without assistance. The fall incident report revealed resident mental status as oriented to place. No other information was provided in this report. Further, review of the care plan revealed no evidence that the care plan had been revised regarding the fall on April 8, 2025. A review of the Medical Center, discharge instructions diagnosis dated April 8, 2025 revealed an unspecified injury of the head, fracture of one rib, on right side. A final report of computed tomography (CT) chest without contrast dated April 8, 2025 at 5:21 a.m. revealed an acute facture in the right 4th rib with 1-2 mm displacement and mild soft tissue swelling around the right 4th rib. Occupational Therapy Treatment Encounter Notes dated April 8, 2025 revealed that the resident appeared to have increased confusion and impaired safety awareness, educated resident and nursing staff on the resident change in status. The note also relayed that the resident was no longer cleared to ambulate in room/to bathroom without staff present, that therapy is recommending that the patient use a wheelchair for mobility, and call for staff to be present for all transfers. An interview was conducted with the Resident #94 on April 8, 2025, at 1:49 p.m., who stated that she had a fall two days prior and one was this morning. The resident declined further interview at that time. During an interview with a Certified Nursing Assistant (CNA/ staff # 9) conducted on April 9, 2025 at 9:31 a.m. , the CNA stated that the resident recently had an unwitnessed fall. The CNA further stated that after the fall, interventions were initiated that included frequent monitoring, calling staff during transfer, and educating resident to use call light. The CNA then stated that CNAs do not document monitoring and supervision of resident in the clinical record, but notify nursing. An interview was conducted with a LPN (staff #6) on April 9, 2025 at 1:16 p.m., who stated that Resident #94 had a decline in mental status including hallucinations and talking to herself. The LPN reviewed the resident's clinical record and stated that the resident was admitted to the facility three weeks ago and had unwitnessed falls on April 7, 2025, and April 8, 2025. The LPN further stated that the fall on April 8, 2025 resulted in a bruise on the resident's right foot and head, and during that incident, the resident's vital signs were monitored, 911 was called, family/provider were notified, and the resident was sent to the ER. The director of nursing then reviewed the Resident #94 hospital records included chest CT that revealed a rib fractured. The LPN then stated that interventions were initiated after the resident's two falls that included frequent monitoring, education on call light, and self-transfer, but the interventions were not updated on the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON/ staff #27) conducted on April 9, 2025 at 1:44 p.m., the DON stated that during admission, residents were evaluated for fall risk, vitals, elopement, skin assessment, and initial care plan would be developed. The DON reviewed the clinical record and stated that the resident had falls on April 7 and April 8, 2025, she further stated that there were no notes regarding updated fall interventions in the clinical record, however updated interventions include use of a wheelchair and assistance with activity of daily living for toileting and transfer. The DON then stated that the facility fall policy would include assess with the appropriate care plan intervention. She then said that the facility did not follow their policy; and, the risk of not having the care plan updated after each fall could result in staff not having full information regarding the resident's medical conditions. Review of the facility's policy titled Care Plan, Comprehensive Person-Centered, revised on March 2022, revealed that assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. Review of the undated facility policy titled Fall revealed that falls can often be an indicator of an impending decline. Each fall must be followed up with and updated in the plan of care with new interventions.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, interview, and review of policy and procedures the facility failed to ensure Enhanced Barrier Protection (EBP) was in place for seven residents (#2, #19, #20, #343, #36, #195, #94) according to professional standards. This deficient practice could result in the increased risk of pathogen transmission. Findings include: -Resident #2 was admitted to the facility on [DATE] with diagnoses that include Pyothorax without fistula and a breakdown (mechanical) of nephrostomy catheter among others. The MDS revealed the resident's BIMS score of 14 and also urinary incontinence and indwelling catheter care. The clinical record revealed a doctor's order for a nephrostomy tube output three times a day. -Resident #36 was admitted on [DATE] with diagnosis including acute respiratory failure with hypoxia with a peripherally inserted central catheter (PICC line LUE location). -Resident #19 was admitted on [DATE] with diagnosis of chronic obstructive pulmonary disease. This resident has a Physician order for Foley catheter care on January 1, 2025. There is no order for EBP measures, however, there was a Physician order to use the facility skin and wound protocol if indicated. -Resident #195 was admitted on [DATE] with primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side. The resident has a G- tube site cleansing order and a daily tracheostomy care ordered by the Physician on April 05, 2025. -Resident #343 was admitted on [DATE] with a primary diagnosis of unspecified severe protein-calorie malnutrition. This resident also has a Foley catheter care and maintenance order by the Physician on April 9, 2025. -Resident #94 was admitted on [DATE] with a primary diagnosis of pneumonia with plans to use long term use of antibiotics. The resident has a PICC line on her right upper extremity (RUE) with a weekly dressing order from the Physician on March 29, 2025. -Resident #20 was admitted on [DATE] with a primary diagnosis of urinary tract infection. The resident is currently wearing a Foley catheter with a catheter care order placed on February 20, 2025. However, the Care Plan failed to reflect on Physician's order for EBP protocol and interventions for the seven residents (#2, #19, #20, #343, #36, #195, #94). There is also no evidence of any interdisciplinary communications to provide this vital universal precaution measure to protect the spread of infections within the facility; including signage outside resident's room visibly posted. An observation was conducted on April 10, 2025 at 2:00 p.m. It was observed that there was no signage identifying the residents' need for EBP. In addition, each of the residents that qualified (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for EBP did not have personal protective equipment readily accessible for staff use. Documentation failed to mention that any of the identified residents refused care plan regarding infection control. An interview with a CNA staff #32 conducted on April 10, 2025 regarding the EBP protocols, the staff #32 stated that she understood that they have to follow procedures such as hand sanitizing prior donning the gloves, and proper doffing of gloves after tending to the residents. The staff #32 also stated that they follow this procedure if there is EBP signage outside the residents' room. However, another CNA staff #19 stated CNAs receive notice from the LPNs/RNs regarding following the EBP protocols. An interview with the Director of Nursing who is also the Infection Preventionist staff #27 conducted on April 10, 2025 at 1:37 p.m revealed that the facility's current understanding of EBP protocol only involved the residents with a history of active multidrug-resistant organisms (MDRO). The staff #27 confirmed that there are no current residents that fit those profile requirements at the facility. When asked about the EBP federal guidelines, the staff #27 stated that, I just got some new literature, and believes that it is a dignity issue having to put the signage outside the residents with no active MDRO. However, when asked about the risks of not following the BP guidance, the staff #27 stated, are obviously the spread of infections. DON reiterated, that up until now, they were up to my expectations. For example, the staff #27 stated that the resident #195 did not have EBP signage but moving forward there will be EBP signage outside this resident's room. A facility EBP policy titled, Enhanced Barrier Precautions dated to 2024 revealed that enhanced barrier protection be initiated for residents with: (i) wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling/ implanted medical devices (e.g., central lines, ports, urinary catheters, feeding tubes, tracheostomy/ ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO; and that, EBP precautions should be used for the duration of the affected resident/s' stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.