

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035107	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/20/2024
NAME OF PROVIDER OR SUPPLIER  Haven of Phoenix		STREET ADDRESS, CITY, STATE, ZIP CODE 4202 North 20th Avenue Phoenix, AZ 85015	
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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581</b></p> <p>Based on documentation, staff interviews and the facility policy and procedures, the facility failed to report an allegation of abuse to the state survey agency and failed to complete and submit a 5-day written investigation timely. The deficient practice could result in residents not being protected and being abused.</p> <p>Findings include:</p> <p>Resident #17 was admitted to the facility on [DATE] with diagnoses that included hypertension, schizophrenia, multiple sclerosis, and anxiety.</p> <p>The care plan dated April 21, 2022 revealed that the resident had an impaired cognitive function. Interventions included to keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion and requires approaches that maximize involvement in daily decision making and activity limit choices, use cueing, task segmentation, written lists, and instructions.</p> <p>Resident #8 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis, unspecified dementia with mood disturbance, anxiety, and major depressive disorder.</p> <p>The care plan dated September 1, 2023 revealed that the resident had a impaired cognitive function/dementia or impaired thought processes related to neurological symptoms. Interventions included to keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion and use task segmentation to support short-term memory deficits. Present just one thought, idea, question or direction at a time.</p> <p>Review of facility documentation dated July 26, 2024 revealed that at 1:20 p.m. it was reported to the Assistant Director of Nursing (ADON/staff #151) that resident #17 told a certified medication technician (CMA/staff #27) that she was touched in the crotch area by another resident. The (ADON/staff #151) interviewed resident #17 and the resident stated that a man with glasses, a dark mustache, and a pot belly touched her in the crotch and in the hole. Resident #17 went down the hall with the ADON, and the case manager (staff #83) and identified resident #8 as the alleged perpetrator.</p> <p>The online report regarding the above allegation of sexual abuse was submitted to the state agency August 16, 2024 at 12:39 p.m.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview conducted on August 16, 2024 at approximately 11:20 am with the Administrator in Training (AIT/staff #150), he stated that about a month ago, resident #17 made an allegation about resident #8 touching her privates. Resident #17 stated that resident #8 touched her crotch area and scratched her when they were sitting in the dining room. He also stated that it was not possible for resident #8 to touch her crotch because she is a larger woman and the area could not be reached while she was sitting down. He stated that the facility did not report the allegation of sexual abuse to the state agency and no one completed a 5-day written investigation. He stated that the facility conducted there own investigation and called the regional nurse about the matter. The consensus was that resident #17 was in one of her delusional phases and it did not happen. He stated that resident #17 also said that resident #8 tried to poison her 5 years ago by putting poop in her mouth. Staff #150 stated that he didn't know what the regulations says about reporting an allegation of sexual abuse and the [NAME] President of Clinical Operations and former Administrator, made the decision to not report the allegation to the state agency.</p> <p>An interview was conducted August 20, 2024 at 2:24 p.m. with the Director of Nursing (DON/staff #35), who stated that allegations of sexual abuse must be reported to the state survey agency within two hours of the facility becoming aware of the allegation.</p> <p>The facility policy, Abuse Policy states that If abuse is witnessed or suspected, reporting and investigation will take place in this manner:</p> <ul style="list-style-type: none"> <li>-Executive Director (ED) will be notified.</li> <li>-ED and witness who is reporting will notify the following entities:</li> <li>-Adult Protective Services</li> <li>-Ombudsman</li> <li>-State Survey Agency</li> <li>-Law enforcement when applicable</li> <li>-Facility Director of Nursing (DON)</li> </ul>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40581</p> <p>Based on record review, staff interviews, and the facility policy and procedures, the facility failed to ensure residents (#26, #25, and #3) were provided with the appropriate level of supervision. The deficient practice could result in the personal space of residents not being respected.</p> <p>Findings include:</p> <p>Resident #26 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, chronic obstructive pulmonary disease, and hypertensive chronic kidney disease.</p> <p>The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 14 indicating the resident was cognitively intact.</p> <p>The care plan dated July 23, 2024 revealed an impaired cognitive function/dementia or impaired thought process related to sexual advances towards staff. Interventions included to monitor/document/report to the medical doctor any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status.</p> <p>A nurse practitioner note dated August 7, 2024 revealed that the resident has dementia issues and some history of being aggression with peers. The resident has been stable for months. Per a progress note dated July 16, 2024 at 7:04 p.m. Note Text: Writer went in to give residents medication. Resident held writer hand and writer ask if he needed anything. Resident made sexual advances to writer stating come closer and give me a kiss. Writer told resident that was not appropriate and walked out of room.</p> <p>Review of a progress note dated August 9, 2024 revealed that at 11:30 a.m. the resident alleged that a female resident struck him on the chest in the hallway, where staff immediately separated them and took them to safe areas. The resident stated that the female resident was blocking the pathway in front of him, when he alarmed her to move, she turned back and hit him on the chest. Upon assessment, the resident sustained no injuries, and bruises and or skin tears were not noted. The Administrator, medical doctor, social worker, and family member were informed immediately.</p> <p>Review of the 5-day written investigation dated August 15, 2024 revealed that the hallway was congested due to a medication cart located on one side of the hallway and an empty wheelchair on the other side of the hallway. Resident #26 was in his wheelchair behind resident #5 and was trying to get around resident #5. The Maintenance Director (staff #60) moved the empty wheelchair, so resident #26 could pass and when he passed by resident #5, she reached out and made contact with the back of resident #26's chest. Staff #60 moved resident #26 down the hallway. Resident #26 was assessed by the Director of Nursing (DON) and no injuries were noted.</p> <p>Review of the progress notes did not reveal documentation regarding the incident that occurred on August 19, 2024 where resident #26 touched resident #3 on the side/stomach area while seated next to each other in the dining room.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident #5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included radiculopathy in the lumbar region, unspecified mood affective disorder, irritability and anger, low back pain, and chronic post-traumatic stress disorder.</p> <p>Review of the care plan dated June 12, 2023 revealed that the resident is on an opiate medication related to chronic pain syndrome. Interventions included to review for pain medication efficacy.</p> <p>The (MDS) dated [DATE] included a brief interview for mental status score of 13 indicating the resident was cognitively intact.</p> <p>The care plan dated August 9, 2024 revealed that the resident has a behavioral problem related to physical behaviors. At times the resident may have behaviors, reaching out to residents/getting residents attention in congested areas as I may become inpatient. Intervention included to anticipate the resident's needs and to identify behavior triggers.</p> <p>A progress note dated August 9, 2024 revealed that resident #5 struck another patient in the chest. Both patients were separated from the situation immediately to a safe environment. Upon assessment, the resident sustained no injuries. The medical doctor, Administrator and family were notified. The care plan was updated.</p> <p>An interview was conducted on August 16, 2024 at approximately 10:15 a.m. with the Maintenance Director (staff #60), who stated that there was an empty wheelchair on one side of the hall and a medication cart on the other. Resident #26 was in his wheelchair behind resident #5, who was also in her wheelchair. Resident #5 looked behind her and told resident #26 to move it. Staff #60 moved the empty wheelchair and resident #26 went around resident #5. Resident #5 tried to fight with resident #26 and the backside of her left hand touched resident #26's midsection of his body, but her movement was weak because she has pain in her arm. Staff #60 reported the incident to the Administrator.</p> <p>An interview was conducted on August 16, 2024 at 10:30 a.m. with resident #26, who stated that he asked resident #5 if he could get by with his wheelchair and she told him to wait. He stated that he said, What do you mean wait. When he went by her, she swung at him and hit his chest with the back of her hand. He stated that it hurt and it scared him because he has a pacemaker. He stated that resident #5 doesn't like him and that about a year ago, resident #5 tried to run into the back of his wheelchair. He stated that he asked resident #5 why she is doing this to him, bullying him, but she didn't answer.</p> <p>An interview was conducted on August 16, 2024 at 10:36 a.m. with Resident #5, who stated that resident #26 hit her wheelchair from behind two times and now her neck hurts. She stated that she asked resident #26, what was his problem and she swung to hit him, but hit the wheelchair. She stated that resident #26 is a big baby and she wants him to stay away from her. She stated that he is always following her around, stares at her, and tries to look under her dress. Resident #5 was not able to give any details as to how, when, or where the resident tried to look under her dress and stated that she feels safe at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on August 16, 2024 at approximately 11:00 a.m. with a certified medication assistant (CMA/staff #27), who stated that resident #5 likes to mumble that she hates people and wants to hit them. She has a history of saying that she hates resident #26, but has never told her why she hates him. Staff #27 stated that she has reported that resident #5 hates resident #26 to a registered nurse/unit manager (RN/staff #120) and (RN/staff #53) over a year ago, before resident #5 was transferred to her current room. She stated that resident #26 does have a history of putting his hands on staff, hugs and gives a little squeeze afterwards, and one nurse said that he tried to kiss her.</p> <p>During an interview with the Administrator in Training (AIT/staff #150) conducted on August 16, 2024 at approximately 11:20 a.m., he stated that resident #26 told him that he was coming out of his room and told resident #5 to stop, so he could get out of his room, but she kept going. When he caught up with her, she reached out with the back of her hand and made contact with his chest. He stated that resident #5 stated that resident #26 bumped into the back of her wheelchair a little bit, and (staff #60) moved the extra wheelchair in the hallway out of the way to make more room, so resident #26 could pass by. She stated that she reached out to resident #26 to tell him not to bump her wheelchair anymore. Staff #150 stated that if resident #5 was saying that she hated resident #26, it probably should have been reported to the Administrator and he would have made sure that staff kept an eye on the residents and verbal abuse can't be tolerated.</p> <p>An interview was conducted on August 16, 2024 at approximately 12:00 p.m. with the Director of therapy, who stated that resident #5 doesn't have the physical ability to extend her arms fully outwards and would not be able to hold her hands up if the slightest bit of pressure was applied. He stated that the resident didn't have the physical strength to hurt resident #26.</p> <p>-Resident #3 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy, major depression, and anxiety.</p> <p>The Minimum Data Set, dated dated [DATE] included a brief interview for mental status score of 8 indicating the resident has a moderate cognitive impairment.</p> <p>Review of the progress notes did not reveal documentation regarding the incident that occurred on August 19, 2024 where resident #26 touched resident #3 on the side/stomach area while seated next to each other in the dining room.</p> <p>Review of the facility internal investigation dated August 16, 2024 revealed that on August 19, 2024 at 5:55 p. m. resident #26 approached resident #3 in the dining room and began tickling her. Resident #3 was heard saying, no and a certified nursing assistant (CNA) rushed to separate the two residents. Resident #3 was assessed and no injuries were observed. Resident #26 was educated about inappropriate behavior.</p> <p>During an interview with the Administrator in Training (AIT/staff #150) conducted on August 16, 2024 at approximately 11:20 a.m., he stated that resident #26 has a history of being touchy with the staff.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on August 20, 2024 at approximately 11:00 a.m. with resident #3, the Business Office Manager (staff #91). Resident #3 stated that she was in the kitchen/dining room area and resident #26 was sitting next to her. Resident #26 grabbed her on her right side with one hand and she said, stop it, stop it, stop it and resident #26 continued doing it. Resident #3 stated that a nurse came into the dining room and told resident #26 to leave her alone, but resident #26 said, no, she is mine and then he went away. She stated that she thinks that resident #26 was trying to hold on to her, he was tickling her. Resident #3 stated that she felt safe, but sobbed during the interview.</p> <p>Staff #91 stated that during a meeting a meeting with the DON and the Administrator, resident #26 was identified as the male resident who had touched resident #3.</p> <p>An interview was conducted on August 20, 2024 at 12:50 p.m. with the Staffing Manager/Resident Relations Assistant (staff #32), who stated that (CNA/staff #110) was present when resident #26 touched resident #3.</p> <p>An interview was conducted on August 20, 2024 at 1:03 p.m. with (CNA/staff #110), who stated that she was in the dining room assisting a resident with eating. She stated that resident #26 and resident #3 were sitting at the same table. CNA #110 asked resident #26 if he wanted a tray and he said, no, she doesn't want me. CNA #110 stated that she turned back to the resident she was assisting when she heard resident #3 say, no and saw resident #26 pull his hand out from resident #3's side/stomach area. CNA #110 stated that she asked resident #3 if she had a problem and the resident said, no. She stated that later she and the medication technician asked resident #3 what resident #26 had done to her and the resident demonstrated on the medication technician's side how resident #26 had tickled her.</p> <p>An interview was conducted on August 20, 2024 at 1: 41 p.m. with a licensed practical nurse (LPN/staff #106), who stated that resident #3 told the (CNA/staff #110) that resident #26 kept tickling her on the stomach and she kept telling him/shouted at him, no and he kept laughing. Staff #110 assessed resident #3 and did not observe any injuries, but resident #3 told staff #110 that she did not like resident #26 putting his hands on her. Staff #106 stated that she interviewed resident #26 and he said that it did not happen, and she educated him about keeping his hands to himself. Staff #106 stated that resident #26 should not be touching resident #3 and reported the incident to the Administrator.</p>		