

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035127	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/28/2025
NAME OF PROVIDER OR SUPPLIER  Haven Health Prescott, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  864 Dougherty Street Prescott, AZ 86305	
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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure that an incident involving allegation of abuse between a staff member and one resident (#11) was reported according to professional standards. The deficient practice could result in unnoted abuse.</p> <p>Findings include:</p> <p>Resident #11 was admitted to the facility on [DATE] with diagnoses that included toxic encephalopathy, pleural effusion, cirrhosis of the liver, and injuries of the head.</p> <p>A late-entry progress note dated April 16, 2025 revealed that on April 15, 2025 at 11:15 p.m., Resident #11 woke up crying and angry, and made allegations that a, chinese man hit her. The progress note revealed that on April 16, 2025, at approximately 1:30 a.m., Resident #11 stated that a Chinese man who worked at the facility hit her; and that, she wanted her husband to call the police and make a report. The progress note further revealed that staff asked the resident about the allegation and she, did not give clear detail. The progress note revealed that the staff called the resident ' s husband at approximately 2:00 a.m. to report what happened, which resulted in the resident ' s husband arriving at the facility at 2:40 a.m. to take her home.</p> <p>Review of the facility investigation report for staff-to-resident abuse dated April 16, 2025 revealed that the incident was reported to the State Agency on April 16, 2025 at 10:27 a.m following a call from Resident #11 ' s husband reporting that a Certified Nursing Assistant, Staff #17, smacked her buttock during her stay at the facility.</p> <p>A telephonic interview was conducted on April 28, 2025 at 1:17 p.m. with a CNA, Staff #17, who stated that the facility ' s policy and process for reporting allegations of abuse would be to report the suspicion or allegation immediately. The CNA stated that there was an incident between himself and Resident #11, which occurred at 11-11:30 p.m. on the night she arrived at the facility. The CNA stated that he heard the resident yelling for help, when he entered the room she was asleep, and she was unable to be woken up with verbal cues because she was hard of hearing. The CNA stated that he approached the resident, tapped her side three times to wake her, and the resident began yelling at him and alleging that the staff were abusing and hurting her, and to leave the room. The CNA stated that he left the room and reported an allegation of an, asian man hitting the resident to the nurse.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 035127
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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>A telephonic interview was conducted on April 28, 2025 at 2:20 p.m. with a CNA, Staff #54, who stated that the facility ' s policy for reporting allegations of abuse was to report to the nurse immediately. The CNA stated that there was an incident between Resident #11 and another CNA, Staff #17, in which the resident reported that a chinese man hit her between 1-1:30 a.m. the night she arrived at the facility. The CNA stated that she did not personally report the allegation to anyone because the nurses were involved and already aware. The CNA stated that she was unaware of when the incident was reported to the supervisors or the Director of Nursing (DON), but she expected it would be done immediately after handling the scenario.</p> <p>A telephonic interview was conducted on April 28, 2025 at 2:31 p.m. with a Licensed Practical Nurse (LPN/Staff #93), who stated that his process for reporting allegations of abuse would be that once abuse was made, he would call the DON or any administration within one hour, or within two hours per the facility policy. The LPN stated that he was aware of an incident between Staff #17 and Resident #11 on April 15th, 2025; and that, the resident was yelling at the CNA to get out of the room and when he did, the resident got into her wheelchair and was in the hallway disturbing other residents. The LPN stated that the resident was yelling that a, Chinese man molested and hit her and that she needed to call her husband to call the police because she needed the, Chinese man reprimanded this was at approximately 1:30 a.m. on April 16, 2025. The LPN stated that he called the resident ' s husband at 2 a.m. and the husband was at the facility by 2:40 a.m. to take her home, the LPN wrote a progress note, and reported the allegation to the Assistant Director of Nursing (ADON) at 3:02 a.m. on April 16, 2025. The LPN stated that the text message to the ADON said, Just letting you know (Resident #11) left against medical advice, was combative and accusatory of bodily injury, doesn ' t want to stay in the room, and I called on-call Nurse Practitioner. The LPN stated that the first allegation was at 11 p.m. on April 15, 2025, the allegation was not reported to the ADON until 3:02 a.m. on April 16, 2025, and it was a nurses judgement call to not report at 11 p.m. because they thought the resident was just confused, and that he did not have enough time to report the allegation because he had multiple residents who needed assistance and so did the other staff on the floor. The LPN stated that they did not follow the facility policy because the allegation of abuse needed to be reported within two hours.</p> <p>An interview was conducted on April 28, 2025 at 3:12 p.m. with the ADON, Staff #40, who stated that allegations of abuse were expected to be reported right away, or within two hours to the state and other applicable agencies by management. The ADON stated that it was the facility ' s expectation of staff to report allegations of abuse immediately, including when staff have only heard someone talking about abuse. The ADON stated that she would expect the same report timeframe if staff thought a resident was confused, had behaviors, or had a history of false accusations. The ADON stated that she was unaware of the allegations made until the morning shift of April 16, 2025; and that, she had not received a text message from anyone reporting the allegation or else she would have reported it immediately.</p> <p>An interview was conducted on April 28, 2025 at 3:23 p.m. with the DON, Staff #101, who stated that allegations of abuse were to be reported by her to the Executive Director (ED), Staff #74, and they would collaboratively report to the required parties within two hours. The DON stated that it was her expectation of staff to report allegations of abuse immediately when they become aware of it. The DON stated that she was unaware of the specific timeline of the allegations, but she knew it happened on the night of Resident #11 ' s admission. The DON also stated that the incident and allegation of abuse were not reported to by night shift staff, but that the facility became aware of the allegation when the resident ' s husband called on the morning of April 16, 2025.</p> <p>(continued on next page)</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>An interview was conducted on April 28, 2025 at 3:35 p.m. with the ED, Staff#74, who stated that the facility policy process for reporting an allegation of abuse was to report right away once management received the allegation, and within two hours of the allegation being made. The ED also stated that it was her expectation of staff to report allegations to whoever was on call immediately. The ED stated that the incident and allegation between Resident #11 and Staff #17 was not reported by the night shift staff to anyone in management.</p> <p>Review of a policy dated June 2022 titled, Abuse Policy, revealed that suspected abuse should have been reported in accordance with the timeframes and standards required by the Centers for Medicare and Medicaid Services (CMS).</p> <p>Review of &amp;sect;483.12(c)(1) in the State Operations Manual, Appendix PP, revealed that the facility should ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p>		