| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035127 | A. Building<br>B. Wing | 08/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Haven Health Prescott, LLC | 864 Dougherty Street<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910<br><br>Based on resident and staff interviews, clinical records review and facility policy, the facility failed to ensure one resident (#34) was not physically abused by another resident (#3). The deficient practice could result in residents being physically injured.<br><br>Findings include:<br><br>- Resident #34 was admitted to the facility on [DATE] with diagnosis that included unspecified dementia, unspecified severity, with other behavioral disturbance, chronic obstructive pulmonary disease, unspecified, unspecified psychosis not due to a substance or known physiological condition.<br><br>The care plan initiated and revised on August 9, 2023 revealed a care plan that stated resident #34 had behavior problem related to refusal of medications, hallucinations, and impaired cognitive function.<br><br>Review of the facility five-day report submitted on September 19, 2023 documented an interview with resident #34 who stated she scratched me as I rolled by referencing resident #3. The report also documented no past encounters with the alleged perpetrator, resident #3. Further interviews with staff documented resident grabs out.<br><br>In a progress note dated September 19, 2023 at 09:25 AM the Director of Nursing (DON/ staff #13)documented that the resident's family was notified of a small skin tear to left elbow after a resident interaction.<br><br>In a progress note dated September 20, 2023 at 4:11 PM, Medical Provider (Staff #106), completed a psychiatric evaluation, documenting that resident #34 was alert and confused, resistive, paranoid at times. Delusions and hallucinations have been chronically noted. Overall psychiatric symptoms have improved over the last number of weeks as her compliance with her medications have improved. Staff #106 also diagnosed and assessed resident #34 with a skin tear of elbow without complication.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11 which showed resident had moderate cognitive impairment.<br><br>(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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - Resident #3 was admitted to the facility on [DATE] with diagnoses that included vascular dementia, unspecified severity, with other behavioral disturbance, major depressive disorder, recurrent, unspecified, anxiety disorder, unspecified, schizophrenia, unspecified, personal history of traumatic brain injury.<br><br>Review of the annual MDS dated [DATE] showed that a BIMS was not conducted, with staff unable to assess her cognition due to her being rarely or never understood. Staff assessed her to be severely cognitively impaired. Further review of the MDS revealed physical behavioral symptoms directed towards others such as, scratching, grabbing. Other physical behavioral symptoms not directed towards others were also identified, such as hitting or scratching self.<br><br>Review of her care plan initiated on August 2, 2023 included a care plan related to resident's altered thought process related to her diagnosis of organic brain damage, vascular dementia and need for antipsychotic medication as exhibited by her combative behavior of scratching, pinching, repetitive behavior, history of wrapping call light cord around her neck, grabbing, striking out at staff and toys to break fixtures. The care plan also included that between January 2, 2019 and November 20, 2019 Zyprexa (antipsychotic medication) was decreased and her Zyprexa was increased on November 27, 2019 and she was started on Depakote (Mood Stabilizer). The Care plan further included that on March 24, 2020 Depakote was increased for increased behaviors for yelling, pinching, and scratching, on August 25, 2020 her Depakote was increased for increased behaviors, on February 15, 2021 it was documented that she punched staff in the face, on October 28, 2021 she was started on Clonazepam (benzodiazepine) for increased behaviors for striking out at staff, grabbing, and pinching, on May 13, 2022 it was documented in the care plan that resident #3 continued to strike out at staff by pinching and screaming and on August 18, 2022 it was further documented that resident #3 continued to grab staff and pinch or dig finger nails into staff's skin, and is combative at times with cares.<br><br>In a progress note dated September 19, 2023 at 08:36am Licensed Practical Nurse (LPN/ staff#107)documented that she was notified by a CNA (Certified Nursing Assistant) that resident was in hall in wheelchair, another resident was also in wheelchair in hall and wheeling past resident who reached out and scratched resident breaking her skin, wound was approximated by oncoming nurse and 3 steri-strips applied, resident was then brought back to her room.<br><br>In a progress note dated September 20, 2023 at 4:12 PM, Medical Provider (Staff #106), completed a psychiatric evaluation, documenting that resident #3 was alert and oriented essentially times 0, resistant with care at times, can be aggressive, pinches or grabs at staff or other residents if given the opportunity. It further included cloth gloves in place to try to minimize any injuries to others.<br><br>In an interview conducted with Certified Nursing Assistant (CNA/Staff #30) on August 1, 2024, she stated she did not work for the facility at the time of the incident, but was aware that resident #3 will grab staff during care causing mild scratches. She stated staff keep the resident at a safe distance from other residents, without isolating her from others. Staff #30 stated resident #3 is provided with increased supervision and has calmed down with her behaviors. She further stated staff will have the resident wear gloves when agitated to prevent any harm to staff or resident, but only for short periods of time. Staff #30 stated she has received online training for abuse reporting and would inform her DON and administrator of any suspected abuse.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Haven Health Prescott, LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 864 Dougherty Street Prescott, AZ 86305 | |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted with Registered Nurse (RN/Staff#82) on August 1, 2024 at 1:08PM, Staff #82 stated resident #34 has no behaviors that are of concern. She stated resident #3 will flail, grab and scratch. She stated staff will place gloves on her when in social activities, but will keep her at a distance from other residents. She stated the resident receives nail care every two weeks, as a preventative measure. She stated she has received a course on abuse upon hire and is required to complete refresher courses. Staff #82 stated if there were any further altercations or harm to another resident, she would immediately report to her supervisor.<br><br>Review of the facility policy titled Abuse Policy states by definition, abuse is the infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, neglect, mental abuse including abuse facilitated or enabled through the use of technology, and misappropriation of property. Potential abusers can be residents, employees, family members, visitors, vendors, or any other person who comes into the facility. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50553<br><br>Based on observation, clinical record review, resident and staff interviews, facility documentation and policy review, the facility failed to ensure the necessary treatment and services were provided for one resident (#1) out of fourteen sampled residents, regarding bowel care. The deficient practice could result in excessive discomfort for the resident.<br><br>Findings include:<br><br>Resident #1 was admitted to the facility on [DATE] with diagnoses that included paroxysmal atrial fibrillation, unspecified dementia, injury of conjunctiva and corneal abrasions of both eyes, and muscle weakness.<br><br>Review of physician orders revealed an order dated July 11, 2024 for implementing a routine bowel care 3 step program if the resident did not have a bowel movement in 3 days.<br><br>Review of the progress notes revealed multiple entries from July 15, 2024 to July 26, 2024 from the Nurse Practitioner (NP) that claim the resident had no constipation or abdominal pain, indicating that the NP was unaware of any constipation issues during this time.<br><br>Review of the physician order dated July 16, 2024 revealed that 30 mL of Milk of Magnesia Oral Suspension could be given as needed for constipation daily.<br><br>Review of the Minimum Data Set (MDS) dated [DATE] revealed that the resident is always incontinent of bowel, and constipation was present. The MDS also revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating that the resident is cognitively intact.<br><br>Review of the facility document titled, TeamHealth Standing Medical Orders, revealed that staff had standing orders which allowed them to address constipation. These orders stated that if the resident had no bowel movement in the last 3 days to order 1 dose of Milk of Magnesia 30mL. If no results by the next morning, the orders instruct to give a Dulcolax suppository. If this is ineffective within 2 hours, the standing orders instruct to give a fleet enema. If these interventions are still ineffective, the staff are instructed to call the provider for further orders.<br><br>Review of the Bowel Movement Task revealed no documented bowel movements from July 18, 2024 until July 23, 2024 at 9:51PM.<br><br>Review of the Medication Administration Record (MAR) for July 2024 revealed that Milk of Magnesia was administered on July 23, 2024 at 09:07AM after over 5 days without a documented bowel movement. The resident proceeded to finally have a bowel movement on July 23,2024 at 9:51PM.<br><br>Review of the care plan entry dated July 23, 2024 revealed a focus that identified the resident has constipation related to decreased mobility and medication side effects. The goal for this entry was that the resident will have a normal bowel movement at least every 3 days. The care plan interventions included following facility bowel protocol for bowel management and keeping the physician informed of any problems.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Further review of the Bowel Movement Task revealed no documented bowel movement from July 24, 2024 until July 28, 2024 at 1:46 PM.<br><br>Review of the nursing documentation titled, Daily Skilled Evaluation - Nursing, on July 27, 2024 to July 30, 2024 revealed that the nurses had charted normal GI function on these assessments. These assessments do not identify constipation or bowel pain.<br><br>Another review of the MAR dated July 2024 revealed that Milk of Magnesia was administered to the resident on July 28, 2024 at 09:24AM after 4 days without a recorded bowel movement. Following administration of the Milk of Magnesia, the resident proceeded to have a bowel movement the same day at 1:46PM.<br><br>An interview was conducted with Resident #1 on July 29, 2024 at 12:56PM in which the resident claimed she has only been having a bowel movement one time a week, and when she does, it is incredibly painful. She further explains that she feels the Milk of Magnesia does not help and wishes she could try something else. The resident elaborates that she has not seen the doctor and is unsure if the nurses are communicating her issue to the doctor.<br><br>An interview was conducted on July 31, 2024 at 10:50AM with a Registered Nurse (RN/Staff #82) in which she denied knowing that Resident #1 was experiencing constipation issues. She also identified that if a resident has no bowel movement in 3 days, the nurse should then follow the standing orders sheet. When asked how soon after giving a laxative or similar medication the nurse should see results, the RN states that she should follow the timeframe in the bowel regimen standing orders.<br><br>After bringing this issue to the attention of the facility staff, the Assistant Director of Nursing (ADON/Staff #7) requested an interview with the surveyor. An interview was conducted with the ADON on July 31, 2024 at 3:53PM in which the ADON stated that the nurse who had cared for Resident #1 on July 22, 2024 had stated she was aware the resident had no BM that day and offered bowel care, but the resident had refused. The ADON stated that the nurse did not chart the offer for bowel care or the resident's refusal, but the nurse plans to make a late entry at this time to address it.<br><br>When requesting facility policy on constipation on July 31, 2024 at 11:45AM, the facility produced a document that stated the facility did not have a policy for constipation, and the facility instead follows provider orders and change of condition procedures.<br><br>Review of the facility policy titled, Assessments/ Care Planning: Change in a Resident's Condition or Status, revealed that the nurse will notify the physician and record in the medical record when there is a significant change in the resident's condition, including conditions that will not resolve themselves without intervention by staff. Further review of this policy revealed that the nurse should notify the physician when the resident refuses medications two or more consecutive times. |