STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035139	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Show Low	2401 East Hunt Street Show Low, AZ 85901

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that a resident (#14) to resident (#33) altercation did not occur. The deficient practice could result in residents being emotionally and physically harmed. Findings include: Resident #14 was admitted to the facility on [DATE] with a diagnoses of unspecified dementia with other behavioral disturbance, Alzheimer's disease, and hallucinations. The behavior care plan dated September 26, 2023 revealed the resident has behavior problems related to impaired cognitive function and Alzheimer's disease. The resident has a history of hallucinations, wandering, and verbal aggression. Interventions included to intervene as necessary to protect the rights and safety of others, and if issues arise, remove from the situation and take the resident to an alternate location as needed. The minimum data set (MDS) dated [DATE] included a brief interview for mental status (BIMS) score of 3 indicating the resident had a severe cognitive impairment. A weekly skin check dated January 4, 2024 revealed that the resident had no new or ongoing skin impairments. Review of the progress notes did not reveal documentation of the resident to resident abuse that occurred on January 5, 2024. A weekly skin check dated January 5, 2024 revealed that the resident had a skin tear approximately 0.5 cm on his right hand. A physician's note dated February 10, 2024 revealed that the resident has had some aggressive behaviors towards another resident recently. No physical altercations. The facility is aware and have moved them farther apart from each other. -Resident #33 was admitted on [DATE] with diagnoses that included Alzheimer's disease, unspecified dementia with other behavioral disturbance, and hallucinations. (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The incontinence care plan dated February 21, 2022 included the interventions to check the resident every two to three hours and assist with toileting as needed, ensure the resident has an unobstructed path to the bathroom. A communication care plan dated February 21, 2022 revealed that resident #33 speaks mostly [NAME] and is extremely hard of hearing. He has difficulty understanding others due to decreased cognition related to Alzheimer's disease. Interventions did not include using an interpreter for the resident's first language, [NAME]. A wandering risk evaluation dated March 28, 2023 revealed that the resident is a high risk for wandering, does not understand what is being said due to language or cognition, and had a recent change of roommates. The behavior care plan dated November 18, 2023 revealed that the resident's behavior problem is related to cognitive impairment and communication barriers. At times the resident may become impatient and frustrated. Interventions included to anticipate and meet the resident's needs, if issues arise, remove from the situation, and intervene as necessary to protect the rights and safety of others The MDS(minimum data set)dated November 30, 2023 included a staff assessment for mental status score of 3 indicating the resident had a severe cognitive impairment. Review of the progress notes did not reveal any documentation pertaining to the resident to resident altercation on January 5, 2024. Review of the room and/or roommate change notice dated January 6, 2024 was not completed; the reason for room transfer was not documented and the staff who completed the form, the Resident Relations Manager (staff #15), was not available for interview. The resource staff (staff #315) did not know the reason for the incomplete form and did not know how the form should be completed. Reasons noted on the form included: resident/family/responsible party request, medical reason, safety, other resident's welfare, bed availability/admission, and other reason. A nurse practitioner (NP) note dated January 10, 2024 revealed that the resident is verbal and can communicate with staff. Memory, complex attention, concentration and language all appear predominately intact. Patient is generally alert and oriented. Patient displays impaired thought production and problem solving. There are apparent severe deficits in one or more areas concerning memory, complex attention, concentration, word finding difficulties and orientation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 5-day investigation dated January 11, 2024 revealed that on January 5, at approximately 12:05 a.m. resident #14 was using the restroom when resident #33 also wanted to use the facilities, and attempted to move resident #14. This interaction resulted in resident #14 sustaining a skin tear approximately 0.5 cm in size on his right hand. Resident #14 told registered nurse (RN/staff #82) that he was using the shared bathroom when resident #33 entered and started pushing him out, leading to an altercation where resident #33 allegedly poked resident #14 with something sharp. (RN/staff #82) separated the residents and washed the skin tear on resident #14's hand, followed by the application of Betadine and a band-aide to the injury. (RN/staff 82) assured resident #14 that he would not have to share a bathroom with resident #33 again. Staff searched for a sharp instrument/weapon and did not find anything. However, there was no documentation to indicate that staff looked at resident #33's fingernails to determine if they were long, pointy, or jagged. The residents were not interviewed until January 8, 2024 and could not recall any details of the situation that occurred on January 5, 2024. Resident #33 was moved to the other side of the facility. Other residents were interviewed, and the feedback, coupled with the lack of evidence for any wider safety issues, indicated that the incident was isolated. An interview was conducted on June 25, 2024 at 2:15 p.m. with the Administrator (staff #1), and resource personnel (staff #115). Staff #1 stated that resident #14 told a registered nurse (RN/staff #82) that resident #33 pushed him and poked him with something. He stated that resident #14 had a skin tear on the hand. He stated that he believes that resident #33 is able to answer simple yes or no questions, but the resident's first language is [NAME] and resident #33 was not interviewed at the time of the incident because (RN/staff #82) doesn't speak [NAME]. He stated that resident #14 and #33 share a room and he was not sure if the (RN/staff #82) found resident #33 in the bathroom or in the bedroom, but believes resident #33 was found near his bed. He also stated that an interpreter was not provided when interviewing resident #33. The facility's policy, Abuse dated 2022 states that the facilities strive to prevent the abuse of all their residents. The facility recognizes that we care for residents with the diagnosis of dementia and other mental illnesses whose behaviors are not always predictable. The facility further recognizes that due to the proximity of our residents to one another and an individual's freedom of choice, that situations may arise where it is not possible to completely prevent all incidents of abuse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on documentation, staff and resident interviews, and the facility policy and procedures, the facility failed to report an allegation of abuse and complete a 5-day written investigation regarding one resident (#62) in the required timeframe. The deficient practice could result in residents being abused. Findings include: Resident #62 was admitted to the facility on [DATE] with diagnoses that included urinary tract infection (UTI), obesity, chronic kidney disease, and muscle weakness. A progress note dated March 24, 2024 revealed that a certified nursing assistant (CNA) went into the resident's room this morning around 6:30 a.m. and asked the resident if she wanted drinks for breakfast and the resident said that she was tired of the people here overpowering her and hitting her. The CNA reported it to the nurse. The MDS(minimum data set) dated March 28, 2024 include a brief interview for mental status (BIMS)score of 15 indicating the resident was cognitively intact. Review of a five-day investigation dated April 5, 2024 revealed that during the investigation, the Administrator (staff #1) was reviewing progress notes and discovered an entry by (CNA/staff #16) dated March 24, 2024 at 4:43 p.m. that stated the CNA went into the resident's room around 6:30 a.m. and asked the resident is she wanted drinks for breakfast and the resident said she was tired of people overpowering her and hitting her. It also stated that the CNA reported it to the nurse. An interview was conducted on June 24, 2024 at 12:57 p.m. with (CNA/staff #16), who stated that she was provided training on abuse, and if a resident says that something happened, she is supposed to report it to the Administrator within two hours. She stated that if the alleged perpetrator is a staff, the staff is sent home until the investigation is finished to keep the residents' safe. She stated that resident #62 told her that staff was hitting her and she reported it to a licensed practical nurse (LPN/staff #51), who instructed her to put it in a progress note. She stated that she asked (LPN/staff #51) if they needed to call anyone and the nurse said no. Then, a couple of days later, she was called into the Administrator's office and he asked her about the resident's allegation, and she was written up a week later for not reporting it. An interview was conducted on June 24, 2024 at 3:32 p.m. with registered nurse (RN/staff #200), who stated that she received training on abuse and if a resident reports an allegation of abuse, she has two hours to report the allegation to the Administrator. She stated that if the allegation involves a staff member, the staff must leave the building while the investigation is being done. She stated that there is a risk of the abuse continuing if it is not reported. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on June 24, 2024 at approximately 4:45 p.m. with the Administrator (staff #1), who stated that if a resident makes an allegation, staff should contact him and the Director of Nursing (DON) immediately to report it. He stated that he has up to two hours to report an allegation of abuse to the state agency. He stated that while he was investigating another allegation, he was reviewing the progress notes for resident #62 and came across a progress note dated March 24, 2024 written by (CNA/staff #16) stating that the resident had said staff were hitting her. He interviewed the the licensed practical nurse (LPN/staff #51) and she told him that (CNA/staff #16) never reported the allegation to her. He stated that (CNA/staff #16) was ultimately responsible for reporting the allegation to him and he only became aware of the allegation of abuse on April 1, 2024. He was aware that the timeline for reporting the allegation of abuse and 5-day investigation were not met. The facility's policy, Abuse dated 2022 states that if abuse is witnessed or suspected, reporting and investigation will take place in this manner: -Executive Director (ED) will be notified. -ED and witness who is reporting will notify the state survey agency. -ED will begin investigation Immediately and complete within 5 working days using the Abuse Investigation Pack minimum of three residents will be interviewed in order to determine if there is a trend. Interviews may also include the alleged perpetrator, witnesses and staff members as applicable. -Suspected abuse will be reported in accordance with timeframes and standards required by CMS.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to complete a thorough investigation regarding abuse for one resident (#62), submit the five-day investigation within the required timeframe, and prevent further potential abuse during the investigation. The deficient practice could result in residents being abused. Findings include: Resident #62 was admitted to the facility on [DATE] with diagnoses that included urinary tract infection (UTI), obesity, chronic kidney disease, and muscle weakness. A progress note dated March 24, 2024 revealed that a certified nursing assistant (CNA) went into the resident's room this morning around 6:30 a.m. and asked the resident if she wanted drinks for breakfast and the resident said that she was tired of the people here overpowering her and hitting her. The CNA reported it to the nurse. The minimum data set (MDS) dated [DATE] include a brief interview for mental status score of 15 indicating the resident was cognitively intact. Review of a five-day investigation dated April 5, 2024 revealed that during an investigation regarding a skin tear, the Administrator (staff #1) was reviewing progress notes and discovered an entry by certified nursing assistant (CNA/staff #16) dated March 24, 2024 at 4:43 p.m. that stated she went into the resident's room around 6:30 a.m. and asked the resident is she wanted drinks for breakfast and the resident said she was tired of people overpowering her and hitting her. The investigation included interviews: -dated April 1, 2024 with resident #62 and she reported that licensed practical nurse (LPN/staff #51) squeezed her leg, but did not provide context for the encounter. -dated April 1, 2024 with therapy (PT/staff #25), who was only asked about the incident when he was pushing the resident in a wheelchair through the doorway and the resident hit her arm resulting in a skin tear. -dated April 2, 2024 with (CNA/staff #16), who stated that she reported the allegation of abuse to (LPN/staff #51). -dated April 4, 2024 with (LPN/staff #51), who stated that (CNA/staff #16) never reported the allegation of abuse to her and denied squeezing the resident's leg. Review of (LPN/staff #51's) time card revealed that she worked on Monday, April 1, 2024 for 12.52 hours and Tuesday, April 2, 2024 for 12.43 hours. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on June 24, 2024 at 12:57 p.m. with (CNA/staff #16), who stated that she was provided training on abuse, and if a resident says that something happened, she is supposed to report it to the Administrator within two hours. She stated that if the alleged perpetrator is a staff, the staff is sent home until the investigation is finished to keep the residents' safe. She stated that resident #62 told her that staff was hitting her and she reported it to a licensed practical nurse (LPN/staff #51), who instructed her to put it in a progress note. She stated that she asked (LPN/staff #51) if they needed to call anyone and the nurse said no. Then, a couple of days later, she was called into the Administrator's office and he asked her about the resident's allegation, and she was written up a week later for not reporting it. During an interview conducted on June 24, 2024 at 1:19 p.m. with a physical therapist (PT/staff #25), he stated that on March 29, 2024, the resident told him that she has problems with (LPN/staff #51), but he did not ask the residents what type of problems, and did not report it to a supervisor. He stated that he remembered that it was March 29, 2024 because it was the same day that he was pushing the resident through the doorway to her room and she hit her arm, which resulted in a skin tear. An interview was conducted on June 24, 2024 at 2:40 p.m. with the Administrator (staff #1), who stated that he only completed one five-day investigation dated April 5, 2024, which included the allegation of abuse that was documented in the progress note dated March 24, 2024 by (CNA/staff #16), the allegation of an accident resulting in a skin tear, and improper continence care. During an interview conducted on June 24, 2024 at approximately 4:45 p.m. with the Administrator (staff #1), he stated that when a resident makes an allegation of abuse, he has up to two hours to report it to the state agency, so staff are to report allegations to him immediately. He stated that the five-day investigation should be submitted to the state agency within five days of the alleged allegation being reported to staff and since (CNA/staff #16) did not inform him of the allegation of abuse, it was not reported to the state agency on time and the five-day written investigation was not submitted on time. He stated that he became aware of the allegation of abuse on April 1, 2024 when he was reviewing progress notes. He also stated that he was not aware of the resident telling (PT/staff #25) that she was having problems with (LPN/staff #51). An interview conducted on June 25, 2024 at 7:18 a.m. with (LPN/staff #51), who stated that resident #62 is always making up allegations and has made prior allegations about her, such as she threw a blanket over the resident's head, she took narcotics from under the resident's pillow, and she squeezed the resident's leg. She stated that she is no longer providing care for the resident. The facility policy, Abuse dated 2022 states that if abuse is witnessed or suspected, reporting and investigation will take place. The Executive Director and witness who is reporting will notify the state survey agency. The Executive Director will begin investigation immediately and complete within 5 working days using the Abuse Investigation Packet. A minimum of three residents will be interviewed In order to determine if there is a trend. Interviews may also include the alleged perpetrator, witnesses and staff members as applicable. Suspected abuse will be reported in accordance with timeframes and standards required by CMS. If the alleged perpetrator is an employee, they will be Immediately suspended pending the results of the investigation.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on record review, staff interviews, and the facility policy and procedures, the facility failed to administer medication as prescribed for one resident's (#62) urinary tract infection (UTI). The deficient practice could result in the infection not being resolved and the infection could worsen. Findings include: Resident #62 was admitted to the facility on [DATE] with diagnoses that included UTI, obesity, chronic kidney disease, and muscle weakness. The order summary included and order dated March 23, 2024 for Cefpodoxime Proxetil (antibiotic) 100 milligrams (mg) oral tablet give one tablet by mouth two times a day for infection for seven days. The care plan dated March 23, 2024 for antibiotic therapy related to a UTI included the interventions to administer medication as ordered and observe for possible side effects every shift. A progress note dated March 27, 2024 at 7:02 a.m. revealed that Cefpodoxime Proxetil 100 mg oral tablet give one tablet by mouth two times a day for infection for seven days was not available and was on order. The MDS assessment dated [DATE] included a brief interview for mental status (BIMS) score of 15 indicating the resident was cognitively intact. A progress note dated March 28, 2024 at 9:04 a.m. revealed that Cefpodoxime Proxetil 100 mg oral was not available. A progress note dated March 29, 2024 at 1:21 a.m. revealed that Cefpodoxime Proxetil 100 mg oral tablet was not available and that facility was still waiting for the medication from the pharmacy. A progress note dated March 29, 2024 at 7:54 a.m. revealed that Cefpodoxime Proxetil 100 mg oral tablet was still on order. A progress note dated March 30, 2024 at 1:23 a.m. revealed that Cefpodoxime Proxetil 100 mg was still on order. A progress note dated March 30, 2024 at 10:52 a.m. revealed that at 9:30 a.m. the resident was sent out to the hospital as patient was complaining of acute abdominal pain noting it must have been from the beans the resident ate yesterday. Review of the Medication Administration Record (MAR) for March 2024 revealed that Cefpodoxime Proxetil 100 mg was not administered from March 27, 2024 through March 29, 2024 due to the medication not being available. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on June 24, 2024 at 3:32 p.m. with a registered nurse (RN/staff #200), who stated that if the resident was prescribed an antibiotic for a UTI and the medication was not given, the resident could get a septic super-infection. The RN stated that if the pharmacy has not delivered the antibiotic, she would check if facility has the antibiotic available in the Pyxis machine, and if they do not have it, she would call the physician to see if they can give the resident another antibiotic, or call another pharmacy to see if they have the antibiotic and will go and pick it up. The RN reviewed the MAR for March 2024 and stated that the antibiotic was not administered to the resident as prescribed. She stated that it was not okay to go without the medication for three days. An interview was conducted on June 24, 2024 at 3:48 p.m. with the Director of Nursing (DON/staff #2) who stated that if a medication was not available, staff should check the Pyxis machine, call the provider and see if another medication can be administered, contact the pharmacy to determine the reason for the delay, or see if the medication is available at another pharmacy. The DON stated that if the resident does not receive the medication, the UTI could get worse and the resident could become super confused and, as with any infection, could become septic. An interview was conducted on June 24, 2024 at approximately 4:45 p.m. with the Administrator (staff #1), who stated that if a medication was not delivered, staff should notify the DON and she can have an emergency order sent to another pharmacy. Review of the the facility policy, Conformity with Laws and Professional Standards dated April 2007 revealed that the facility operated and provided services in compliance with current federal, state, and local laws, regulations, codes and professional standards of practice that apply to our facility and types of services provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure two residents (#1 and #7) were provided the level of supervision needed to prevent elopement and prevent one resident (#62) from an accident with injury. The deficient practice could result in residents being physically and emotionally injured. Findings include: Regarding Resident #1: Resident #1 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, visual hallucinations, restlessness and agitation, and wandering in diseases classified elsewhere. A physician's note dated January 23, 2024 revealed that the resident's prognosis was poor. The patient continued to be quite confused and malaised and the physician did not think that the resident should ever be outside of 24/7 supervised care. It was also noted that the physician believed that a long-term care facility was best for him and that the resident may need to be considered for a locked behavioral unit. A progress note dated January 24, 2024 at 10:57 a.m. revealed that the resident left out of the back door and walked towards the hospital and that he was a flight risk. A progress note dated January 24, 2024 at 12:56 p.m. revealed that the resident made a second attempt to elope and the staff had to go outside after him. A care plan dated January 24, 2024 revealed that the resident had a behavior problem related to wandering/exit seeking and that the resident has dementia. Interventions included wearing a Wanderguard on the wrist at all times. A physician's progress note dated January 25, 2024 revealed that the resident continued to be a wander risk and will probably need to be considered for the locked cognitive impairment unit at the other nursing facility. The minimum data set (MDS) dated [DATE] included a brief interview for mental status (BIMS) score of 3 indicating the resident had a severe cognitive impairment. A progress note dated February 2, 2024 revealed that resident made four attempts to leave the building today. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note dated February 5, 2024 at 3:14 p.m. revealed that the resident set the Wanderguard off at 1:45 p.m. and a certified nursing assistant (CNA) redirected the resident to the locked outdoor smoking area. It noted that the receptionist went to pick up the resident and let staff know the resident was not there. Further, the noted revealed that a registered nurse (RN/staff #200) asked the receptionist to drive around the area and look for the resident, while staff continued to search the facility property. Also, the note stated that the RN called the receptionist at 2:14 p.m. to see if the receptionist had located the resident and she had found the resident by some townhouses behind Home Depot. The noted stated that the resident was returned to the facility and assessed for injuries. A progress note dated February 6, 2024 revealed that the resident and the resident's daughter were made aware that the resident would be transferred to another facility due to being an elopement risk. The resident and family were agreeable to the plan of care as it was in the best interest for safety purposes. The five-day written investigation completed by the Administrator (staff #1) dated February 9, 2024 revealed interventions following the elopement included the installation of an alarm on the therapy door to prevent similar incidents from occurring in the future. An interview was conducted on June 25, 2024 at 10:08 a.m. with an RN (saff #200), who stated that residents were assessed for being a wandering risk when they are admitted to the facility. The RN stated that when residents were a high risk, the physician was notified, so they can get an order for a Wanderguard. The RN stated that the resident wore the Wanderguard on their wrist and there were sensors on the doors of the building, so an alarm would go off and the door locked when the resident got near the door. The RN stated that resident #1 eloped through the door in the therapy room because the door did not have a sensor on it and he was found at The Home Depot. The RN said that when a resident elopes, there was a risk of the resident being injured, such as getting hit by a car, or getting lost. -Regarding Resident #7: Resident #7 was admitted to the facility on [DATE] with diagnoses that included encephalopathy, alcohol dependence with withdrawal, and dysphagia, oral phase. A progress note dated October 28, 2020 revealed that the resident was observed by housekeeping opening a window and exiting the facility. It noted that the housekeeper alerted the staff, who then exited through the side door to approach the resident and the resident ran across the street towards the hospital and threw rocks at the staff following him. The note reveavled that resident #7 was observed by hospital security and taken down to determine safety concerns and then the resident was taken to the emergency room . A physician's note dated October 30, 2020 revealed it was a late entry and that the resident continued to have difficulties with wandering and behaviors. It noted that staff caught the resident trying to climb out a window the other day and the resident continued to wander into other residents' rooms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035139	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Show Low	2401 East Hunt Street Show Low, AZ 85901

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan dated October 30, 2020 revealed that the resident had the potential for elopement from the facility related to dementia. Interventions included to have a Wanderguard in place for safety, verify the resident's presence on the nursing unit or facility every hour, and when the resident verbalized leaving to distract resident with activities. A progress note dated October 31, 2020 at 5:40 a.m. revealed that the resident left against medical advise through a room window and that the resident had kicked out the screen. A progress note dated October 31, 2020 at 6:22 a.m. revealed that the resident was not in his room at bed check at 5:00 a.m. It noted that the resident was on Clostridioides difficile (C-Diff) isolation. It further noted that the staff were alerted and the facility was searched and found that the blinds in the window were lifted and the widow was closed, but the outside screen was off of the window. It also noted that the DON, Administrator and the police were called. A progress note dated October 31, 2020 at 12:28 p.m. revealed that the LPN talked to an officer and gave the officer the information to contact the family. A progress note dated November 1, 2020 at 11:17 a.m. revealed that a registered nurse (RN) contacted the resident's sister to inquire whether she had seen or heard from the resident and that the sister stated that she had not heard from the resident. A progress note dated November 2, 2020 at 8:15 a.m. revealed that (RN) spoke with the resident's sister to ask whether she had heard from or seen the resident. It stated that the sister stated that the police department picked the resident up in Pinetop and took him to the hospital. Review of the progress notes did not reveal that IDT meetings occurred to determine if new interventions needed to be put into place after each elopement occurred. The five-day written investigation dated November 11, 2020 revealed that at approximately 5:30 a.m. staff was making rounds and noticed that the resident was not in his room and that it was strange because the resident was on C-Diff isolation. The information revaled that the screen on the window was observed lying on the ground, but the window was closed. It was also noted that the resident was last seen in his room on October 31, 2020 at approximately 5:00 a.m. Further, the stated revealed that the resident was finally located by the police on October 31, 2020 at approximately 7:00 p.m. at a nearby establishment and was taken to a local hospital where he was admitted . An interview was conducted on June 25, 2024 at 11:48 a.m. with the Director or Nursing (DON/staff #2), who stated that the facility does admit residents who are a wandering risk and the residents' get a Wanderguard bracelet that sets off an alarm when the residents go by the door. The DON stated that she did not think they have the alarms on the windows. She stated that the door would be closed if a resident is on isolation for C-Diff and should be checked every hour if the resident was a wandering risk. The DON stated that fifteen minute checks were not feasible because staff had to provide care to other residents, and if a resident had gone out the window, the resident should be in a room closer to the nurse's station. The DON thought there should be an IDT meeting to discuss the event and see if more interventions needed to go into place. She stated that there were a risk of the resident being injured or lost. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy, Behavior/Mood/Cognition: Wandering and Elopements dated January 1, 2024 revealed that the facility will identify residents who were at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. The policy further stated that if identified as at risk for wandering, elopement, or other safety issues, the resident's care plan would include strategies and interventions to maintain the resident's safety. Regarding Resident #62 -Resident #62 was admitted to the facility on [DATE] with diagnoses that included urinary tract infection (UTI), obesity, chronic kidney disease, and muscle weakness. The MDS dated [DATE] include a brief interview for mental status score of 15 indicating the resident was cognitively intact. Review of a progress note dated March 29, 2024 revealed that the resident was being transferred to her room in her wheelchair by a physical therapist (PT/staff #25) and her right arm made contact with the doorframe causing a skin tear to the upper right forearm. The arm was cleaned and dressed. The order summary revealed an order dated March 29, 2024 for skin tear to the right forearm, clean the wound, wash and apply dressing until healed. An interview was conducted on June 24, 2024 at 1:19 p.m. with a physical therapist (PT/staff #25), who stated that he did receive training on the use of wheelchairs from the facility. He stated that they are supposed to push a resident forward through the doorway and to make sure the elbows are in and not outside of the armrest. The PT said that the risk was that the resident could be injured and cause a skin tear. He acknowledged that he did push the resident through the bedroom doorway and she did hit her arm resulting in a skin tear. An interview was conducted on June 24, 2024 at 3:32 p.m. with (RN/staff #200), who stated that she did receive training on equipment including wheelchairs, and when staff push a resident through the door, staff should make sure that the resident's arms and legs are not poking out, so there is enough room to clear the doorframe. Otherwise, she said, there was a risk that the resident could get hurt, such as a skin tear. An interview was conducted on June 24, 2024 at 3:48 p.m. with the (DON/staff #2), who stated that staff are trained to use wheelchairs safely. She stated that staff should make sure the wheelchair can clear the doorframe, and that the residents legs are are not dragging on the floor and arms are not hanging over the sides of the wheelchair. She stated that if staff don't check these things, there is a risk of the resident being injured. An interview was conducted on June 25, 2024 at 7:18 a.m. with licensed practical nurse (LPN/staff #51), who stated that a skin tear occurred when the resident was being pushed through her bedroom doorway. She said she did not witness the incident, but she cleaned the skin tear. The LPN stated that the resident told her that the therapist did it when he pushed her through the door. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy, Resident Safety: Safety and Supervision of Residents dated January 1, 2024 revealed that the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly.