STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035165	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Tucson	3705 North Swan Road Tucson, AZ 85718

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911 Based on staff interviews, review of records and facility policies and procedures, the facility failed to ensure that medical records were documented accurately and in accordance with accepted professional standards and practices for one resident (#1) regarding fall risk assessments. The deficient practice could result in inaccurate documentation of the residents medical history and needs. Findings include: Resident #1 had a most recent admission on June 24, 2024 with diagnosis including metabolic encephalopathy, cerebral infarction, acute respiratory failure, Alzheimer's disease, hypertensive heart disease, dysarthria, anarthria, asthma, protein-calorie malnutrition and major depressive disorder-recurrent. A review of the quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 8, suggesting moderate cognitive impairment. Section J of the MDS revealed that the resident had one noted fall with injury since admission or reentry. A review of the resident's care plan revealed a focus area noting that the resident is at risk for falls and injury post actual falls. A review of the progress notes dated for June 23, 2024 at 7:09 P.M. revealed that the resident was discovered by his roommate post fall with 'copious' amounts of blood on the floor and lacerations to the right upper eyebrow, as well as bruising to the bilateral knees and elbow. Notes further revealed that the resident was stabilized prior to hospital transfer. The progress notes further revealed an entry dated June 24, 2023 at 6:29 A.M. notating that the resident had returned to the facility. Change of condition charting was observed on June 24 and 25, 2024 referencing the fall. A review of the hospital discharge documentation dated June 24, 2024 revealed resident #1's discharge diagnosis included an elbow contusion, fall and head injury. A review of the admission fall risk evaluation dated June 24, 2024 revealed that the assessment scored the resident as having had no falls during the past 90-days; however, the resident had been transferred from the facility to the hospital as a result of a fall. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on September 3, 2024 at 9:48 A.M. with staff #14, CNA (certified nursing assistant). Staff #14 stated that fall risk assessments are completed for residents and once a concern had been identified based on the assessment, interventions may include falling leaf program, mobility assist bars, fall mats on both sides of the bed and more frequent monitoring. An interview was conducted on September 3, 2024 at 12:12 P.M. with the MDS nurse (staff #31). Staff #31 stated that the fall should have been documented on the fall risk evaluation, but stated that he felt it wouldn't have made a change in the implementation of services but would have made a change in the scoring, resulting in an inaccurate assessment. An interview was conducted on September 3, 2024 at 12:43 P.M. with the DON (director of nursing/ staff #52). Staff #52 stated that the expectation is that an accurate fall risk evaluation is completed for each resident. After the DON reviewed the fall risk evaluation dated June 24, 2024, she stated that the fall should have been documented as it was noted in the facility progress notes and the hospital discharge documentation. The DON stated that the risk could include inaccurate documentation and potential for miscommunication among staff. A review of the facility policy entitled Fall Prevention Program dated 2014 version 0414 revealed that all new admissions are to have a thorough review of history as well as a fall risk evaluation completed with assistns a risk level, it further stated that if there is a history of falls, the causative factors should be identified and care plan interventions should be implemented; however, the most recent fall, which had occurred in the facility, was not documented on the fall risk evaluation.

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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 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** 47911 Based on staff interviews, review of records and review of policies and procedures, the facility failed to ensure that physician orders were in place for fall preventative measures, regarding fall mats for one resident (#1). The deficient practice could result in non-ordered services being provided for residents. Findings include: Resident #1 had a most recent admission on June 24, 2024 with diagnosis including metabolic encephalopathy, cerebral infarction, acute respiratory failure, Alzheimer's disease, hypertensive heart disease, dysarthria, anarthria, asthma, protein-calorie malnutrition, and major depressive disorder-recurrent. A review of the quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 8, suggesting moderate cognitive impairment. Section J of the MDS revealed that the resident had one noted fall with injury since admission or reentry. A review of the resident's care plan revealed a focus area noting that the resident is at risk for falls and injury post actual falls and that the interventions include bilateral landing strips placed on both sides of the bed. A review of the physician orders in the resident's medical record, revealed no evidence of a current order for fall mats/ landing strips. An observation was conducted on September 3, 2024 at 11:20 A.M. Resident #1 was observed to have bilateral fall mats next to his bedside. An interview was conducted on September 3, 2024 at 10:02 A.M with staff #65, LPN (licensed Practical Nurse). Staff #65 stated that when a resident has a known history of falls, they will often have the bed lowered, have a fall risk bracelet, fall mats, and or bolsters. Staff #65 stated that fall mats require orders prior to implementation and that these would also be documented in the care plan. An interview was conducted on September 3, 2024 at 11:52 A.M. with staff #22 (LPN). Staff #22 stated that orders are required for landing strips/ fall mats. Staff #22 reviewed the record for resident #1 and stated that the care plan did call for landing strips, but confirmed that no physician orders were in the record for the landing strips/ fall mats. An interview was conducted on September 3, 2024 at 12:43 P.M. with staff #52 (DON-director of nursing). Staff #52 stated that fall mats require an order. Staff #52 reviewed the medical record for resident #1 and stated that the need for fall mats was documented in the care plan but that there was no order for the fall mats observed in the record. Staff #52 stated as long as the fall mats were in the resident's room that there was no direct risk to the resident but that the risk would include a lack of communication among staff members. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy entitled Assessments/ Care Planning: Physician Services dated January 1, 2024 revealed that physician orders and progress notes are to be maintained in accordance with current OBRA regulations and facility policy; however, the electronic health record for resident #1 revealed no evidence of an order for fall mats/ landing strips.