| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035172 | A. Building<br>B. Wing | 08/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Haven of Safford | 1933 Peppertree Drive<br>Safford, AZ 85546 |

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<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** 47954<br><br>Based on clinical record reviews, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure that two residents (#30) and (#60) were free from physical abuse resulting in injury by other residents (resident #90). The deficient practice could result in further incidents of resident to resident abuse.<br><br>Findings include:<br><br>Regarding resident #90 and resident #30<br><br>-Resident #30 was admitted to the facility on [DATE], with diagnoses that include Gout, Alcohol dependence, chronic obstructive pulmonary disorder, and hypertension.<br><br>A behavioral care plan revised December 6, 2023 revealed the resident was at risk of impaired cognitive function replaced to dementia with a noted intervention of keep resident's routine consistent to provide consistent caregivers in order to reduce confusion.<br><br>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 03 which indicated the resident had significant cognitive impairment.<br><br>-Resident #90 was admitted to the facility on [DATE], with diagnoses that include Dementia, pneumonia, sepsis, alcohol abuse, transient ischemic attack, and hypertension.<br><br>A behavioral care plan dated April 8, 2024 revealed the resident was at risk of wandering, sleeping in other resident's rooms, and physical behaviors towards staff and other residents. The goal was the resident will demonstrate effective coping, with noted interventions of allowing the resident to make decisions about his care, give clear explanations to the resident of all care activities, and administer medications as ordered.<br><br>However, there was no noted interventions to address the wandering behavior, or the physically aggressive behaviors towards staff and residents.<br><br>Review of the Admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 09 which indicated the resident had moderate cognitive impairment.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035172 | A. Building<br>B. Wing | 08/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Haven of Safford | 1933 Peppertree Drive<br>Safford, AZ 85546 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the clinical record progress notes for resident #90 dated July 30, 2024 at 11:49 a.m. revealed the resident getting into residents and staffs face several times and yelling, and clenching his fists regarding his keys, when trying to redirect and distract became undoable.<br><br>A second progress note dated August 4, 2024 at 8:05 a.m. revealed that resident #90 was wandering the halls, with multiple attempts to redirect the resident to dining room or resident's room due to angry outbursts.<br><br>A third progress note dated August 4, 2024 at 12:40 p.m. revealed that the resident #90 had multiple angry outbursts this shift over many different events. Resident needing to be constantly redirected away from other residents as resident gets mad and upset very easily.<br><br>An incident progress note dated August 7, 2024 at 9:17 a.m. revealed resident #90 had multiple angry outbursts this AM shift. Resident #30 had accidently bumped resident #90's knee with a wheelchair. Resident #90 verbally warned resident that if you don't move or if you do that again you will get hit while having his fist in the air. Resident #30 was moved away from resident #90 by staff.<br><br>However, the note continues that at approximately 9:08 a.m., resident #90 was yelling and screaming and was found in the dining room and had hit resident #30 in the face for hitting me in the knee with the wheelchair.<br><br>A review of the clinical record progress notes for resident #30 dated August 6, 2024 at 7:03 a.m. revealed patient was hit in the right eye by another resident. Bruising to the right eye, applied ice and gave ibuprofen PRN for the pain and swelling, will continue to monitor eye<br><br>Regarding resident #90 and resident #60<br><br>-Resident #60 was admitted to the facility on [DATE], with diagnoses that include dementia, diabetes mellitus type 2, urinary tract infections, depression, insomnia, and hypertension.<br><br>A behavior care-plan initiated November 3, 2022 revealed the resident has a cognitive impairment problem related dementia, with noted interventions of keeping the resident's routine consistent as much as possible in order to decrease confusion.<br><br>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 03 which indicated the resident had significant cognitive impairment.<br><br>An interview was conducted with a Registered Nurse (RN/staff #25) on August 20, 2024 at 12:32 p.m. The RN stated that when the resident was moved to the long-term care side of the facility, he started becoming more confused and having behaviors, before being moved to the behavior unit. The RN noted as time has gone on, resident #90 became increasingly agitated, would make sexual advances, and go into other people's rooms. The RN further stated that resident #90 did physically hit a couple of people, including resident #30. The RN noted that because of staffing challenges, the resident was on 1:1 at certain times, but not all the time.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035172 | A. Building<br>B. Wing | 08/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Haven of Safford | 1933 Peppertree Drive<br>Safford, AZ 85546 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview with a Certified Nursing Assistant (CNA/staff #45) was conducted on August 20, 2024 at 12:50 p. m. The CNA stated that resident #90 is very spontaneous, and a few times was aggressive like if he wanted to leave, he would get mad. He further stated resident #60 got an abrasion on their face from resident #90, and that resident #90 gave resident #30 a big black eye. The CNA further stated that they try to redirect him if he's getting angry and if it causes yelling try to do a 1:1 for him.<br><br>An interview with the Director of Nursing (DON/staff #5) was conducted on August 20, 2024 at 1:53 p.m. The DON stated that resident #90 initially was confused but redirectable, but started wandering and exit seeking and was moved to the behavior unit. The DON stated that a few weeks ago resident #90's behaviors started to rapidly escalate. The DON further stated that they had tried many redirection methods around his behaviors that often happen at meal times, such as double portions that was working well. The DON concluded that it was just the two incidents where he got physical, one with resident #30 and one with resident #60, and that the resident #90 was ultimately discharged to another skilled nursing facility in Tucson, because he was no longer appropriate.<br><br>A review of facility policy titled "Abuse Policy revealed that they strive to prevent the abuse of all residents. They recognize residents with the diagnosis of dementia and other mental illnesses whose behaviors are not always predictable. Further they recognize that due to the proximity of the 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. |