STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035233	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Globe	1100 Monroe Street Globe, AZ 85501

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** 47910 Based on clinical record review, staff interviews, and facility documentation and policy review, the facility failed to ensure adequate supervision was provided for two residents (#3) and (#4) to prevent further resident to resident altercations. The deficient practice could result in further incidents of inadequate resident supervision. Findings include: Regarding residents #1 and #2: -Resident #1 was admitted to the facility August 27, 2024 with diagnosis including unspecified dementia, unspecified severity, with other behavioral disturbance, dementia in other diseases classified elsewhere, moderate, with agitation. A care plan initiated in April 2023 and revised July 2023 revealed the resident had a focus for behavior problems related to resistance to care and wandering and impaired cognitive function/dementia or impaired thought processes related to short and long-term memory loss and dementia. Interventions included administer meds as ordered, intervening as necessary to protect the rights and safety of others. Approach and speak in a calm manner, divert attention, remove from situation and take to alternate location as needed. The quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 07, indicating severe cognitive impairment. Further review of the MDS revealed no indicators for mood or behaviors. The progress notes dated April 19, 2024 documented an incident note that revealed CNA reported that resident #1 was struck by another resident and that the patients were separated from each other. The note further states resident #1 had no marks on her and denied pain. Appropriate staff and providers notified of the incident. The provider notes dated April 20, 2024 revealed resident #1 reported no complaints of right shoulder pain due to being punched by a resident. Per the provider note staff were to monitor pain and level of consciousness (LOC). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER Haven of Globe		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 Monroe Street Globe, AZ 85501	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #2 was admitted to the facility March 14, 2016 with diagnosis including dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, major depressive disorder, recurrent, mild. A care plan initiated in April 2024 revealed the resident had a focus for use of mood stabilizer medication (Depakote) r/t dementia with behaviors and potential to demonstrate physical behaviors hitting others r/t Anger, Dementia, Poor impulse control, physical behaviors. Interventions included to Give mood stabilizer medications ordered by physician. Monitor/document side effects and effectiveness, target symptoms/Behavior Tracking:(mood swings) and Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. The quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 99 indicating resident was unable to complete the interview. Further review of the MDS revealed a diagnosis for dementia with no indicators for behaviors. The progress notes dated April 19, 2024 revealed resident #2 struck another resident after she bumped his wheelchair while ambulating and attempting to pass resident #2 who was seated in his wheelchair in the hallway. The note states that resident #2 struck the resident on her left arm and that both residents were immediately separated while resident was assessed for injuries. A physician note dated April 20, 2024 revealed resident was seen for being aggressive. The note revealed resident did not recall his punching on one of the residents. The note further documents increasing aggressive behavior. Review of the facility investigation with discover date of April 19, 2024 included that both resident #1 and #2 were interviewed. Per the documentation, resident #1 stated when asked how she was doing that she was a little sore. When asked what happened resident #1 stated I got bucked off a horse, but I am doing better. Resident #2 was interviewed and when asked how he was doing resident #2 stated yeah. Resident #2 was asked if he had any run-in with another resident, resident #2 laughed and stated no, no, no. Continued review of the facility investigation included that the facility identified this incident was unsubstantiated due to the fact that there was no willful intent to cause harm from either of the residents and that both residents are wandering risk, impaired thought process, and unaware of own safety needs. An observation was conducted December 6, 2024 at 3: 26 p.m. of the behavioral unit where both residents #1 and #2 reside. Observed both resident's in the dining area with other unidentified residents unsupervised. No staff present. This surveyor continued observation of the residents. Two staff later identified as certified nursing assistant (Staff#61/CNA) and Activities Manager (Staff #10/Activities) walked by at 3:31 p. m. An interview was conducted on December 6, 2024 at 3: 32 p.m. with Activities Manager (Staff #10/Activities) Staff #10 stated she had provided activities on the unit and had left the unit at 2:00 p. m. Staff #10 stated the residents were left in the dining room and that the staff were somewhere on the unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on December 6, 2024 at 3:33 p.m. with (Staff#61/CNA). Staff #61 stated she had taken the CNA course at the facility and was a [NAME] for the facility prior to that. She stated the staff receive report every morning for any resident that needs an extra eye on them and to keep them close to us and to keep staff on the unit. Staff #61 stated she was unaware of any altercations with any of the residents currently in the dining area. Staff #61 stated she was unaware of the incident with resident #1 and #2 and they should not be left alone unsupervised. Staff #61 stated if there was an altercation with any of the residents she is to de-escalate the situation - remove the residents and report the incident. Staff #61 stated the residents #1 and #2 had been left alone approximately 20 minutes while she provided care for another resident that required the assist of two. Staff #61 stated residents who had a prior altercation require supervision and monitoring because they are a high risk- staff #61 further stated the risk of not supervising or monitoring those residents can be cause for recurrent incidents. An interview was conducted on December 6, 2024 at 4:12 p.m. with (Staff#12/LPN) Staff # 12 stated he could not recall the incident but the information he documented in the progress note is correct. Staff #12 stated resident #2 has behavior issues he likes his space becomes verbally aggressive and tries to intimidate the other residents. Staff #12 stated resident #2 should not be left alone unsupervised, not monitored with other residents. Staff #12 stated there are two CNA's on the unit plus a nurse. Staff #12 stated it is difficult to monitor the residents when he is down the hallway or outside of the unit passing medications. Staff #12 stated there is not enough staff on the unit to supervise and monitor the residents, given that some of the residents require two people to provide their care. Staff #12 stated the risk of leaving residents on the unit unsupervised or monitored is they can become verbally and physically aggressive. Regarding residents #3 and #4: -Resident #3 was admitted to the facility September 16, 2020 with diagnosis including unspecified dementia, unspecified severity, with mood disturbance, unspecified dementia, unspecified severity, with other behavioral disturbance, major depressive disorder, recurrent, unspecified. A care plan initiated in April 2024 had a focus for impaired cognitive function/dementia or impaired thought processes r/t short term memory loss, dementia and at risk for misappropriation, neglect, abuse, and/or exploitation related to dementia, resides in wandering unit, physical aggression received from another resident. Interventions included provide with compatible staff whenever possible, separate resident from an aggressor, administer meds as ordered. The quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 05 indicating severe cognitive impairment with no indicators for behaviors or mood. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An alert charting note dated March 1, 2024 for change of condition summary revealed the following documentation; At approximately 1210 while passing noon medications, I heard resident #3 as she was seated to her usual dining table talking loudly, I looked over and saw resident #4 standing behind her wheelchair tugging at the handle trying to pull it backwards. resident #3 continues to state, leave me alone, stop it, don't do that. I then proceeded to walk towards the two resident's when resident #3 tells resident #4 to leave her alone, is when I witnessed him bend down, push his left forearm into her neck, and punched resident #3 twice in the right shoulder arm and proceeded to hit her in the face when I placed my hands on his chest and grabbed both arms to block his arm and held his chest to place space between resident #4 and resident #3 , resident #4 stumbled backwards, where I was able to get resident #3 away when the other CNA's in the Unit came to assist with getting resident #4 out of the dining room. Incident was reported to DON, Charge Nurse and Administrator. Resident #3 was visibly and emotionally upset and distraught by the incident, resident #4 was removed and redirected down the hall by CNA's in the unit. Resident #3 was assessed and taken back to her room. Resident #3 was assessed, did not have any bruising noted to her right upper arm, shoulder or face. No cuts or open areas to her body. Resident #3 vital signs are stable. Review of the physician progress note dated March 2, 2024 stated reason for visit - resident got hit by a male resident and complained of shoulder pain with a recommendation for Voltaren for symptom management. Review of the facility investigation with discover date of March 1, 2024 included that both resident #3 and #4 were interviewed. Resident #3 reported that she was sitting in the dining room at the table and a man came to her and started tugging on her wheelchair, she stated stop, don't do that and resident #3 stated he reached down trying to mess with the brakes then she reached down with her hand to stop him and when she did he leaned into her and punched her twice in the right upper arm she stated after the incident she went straight to her room. An attempt was made to interview resident #4 but revealed resident cognitively understand and continued to wander away from the interviewers. Additional review of the facility investigation revealed a witness statement dated March 1, 2024. Witness states he observed the incident from 20-25 ft. The statement details resident #4 initially circled resident #4 and became verbally loud while standing above resident #3. The witness states resident #3 became frightened and raised her voice asking resident #4 to get away from her. Resident #4 then placed his forearm in a blocking fashion against her neck and pushed. The witness states resident #3 became extremely frightened and became louder when resident #4 proceeded to cuss and 'landed 2-3 punches about resident #3 upper body. The witness states staff separated resident # 3 by removing her from the dining room and that resident #4 remained in a defensive mode for the next 15 minutes or more. A telephonic interview was conducted on December 6, 2024 at 1:36 p.m. with registered nurse (Staff #30/RN). Staff # 30 had provided a previous interview regarding another incident in the facility. Staff # 30 stated she could not continue with the interview as she was on vacation and her family was waiting on her, but that everything is documented in my nursing note, I saw resident #4 hit resident #3 multiple times. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Haven of Globe		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 Monroe Street Globe, AZ 85501	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on December 6, 2024 at 3:33 p.m. with (Staff #61/CNA). Staff #61 stated she had taken the CNA course at the facility and was a [NAME] for the facility prior to that. She stated the staff receive report every morning for any resident that needs an extra eye on them and to keep them close to us and to keep staff on the unit. Staff #61 stated she was unaware of any altercations with any of the residents currently in the dining area. Staff #61 stated she was unaware of the incident with resident #1 and #2 and they should not be left alone unsupervised. Staff #61 stated if there was an altercation with any of the residents she is to de-escalate the situation - remove the residents and report the incident. Staff #61 stated the residents #1 and #2 had been left alone approximately 20 minutes while she provided care for another resident that required the assist of two. Staff #61 stated residents who had a prior altercation require supervision and monitoring because they are a high risk- staff #61 further stated the risk of not supervising or monitoring those residents can be cause for recurrent incidents. An interview was conducted on December 6, 2024 at 3:58 p.m. with Director of Nursing (DON/staff #43) stated staff are informed during report about resident incidents and any supervision or monitoring needed. Residents should be observed for escalation of any behaviors and remove from the situation. The DON stated the risks associated with not providing supervision is verbal or physical aggression and feel there is sufficient staff to provide these preventative measures. Review of the facility policy titled Resident Rights/Dignity: Abuse, Neglect, Exploitation and Misappropriation Prevention Program states Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: b. other residents

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NAME OF PROVIDER OR SUPPLIER: Haven of Globe		STREET ADDRESS, CITY, STATE, ZIP CODE: 1100 Monroe Street Globe, AZ 85501	

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47910 Based on clinical record review, staff interviews, and facility documentation and policy review, the facility failed to ensure adequate supervision was provided for two residents (#3) and (#4) to prevent further resident to resident altercations. The deficient practice could result in further incidents of inadequate resident supervision. Findings include: Regarding residents #1 and #2: -Resident #1 was admitted to the facility August 27, 2024 with diagnosis including unspecified dementia, unspecified severity, with other behavioral disturbance, dementia in other diseases classified elsewhere, moderate, with agitation. A care plan initiated in April 2023 and revised July 2023 revealed the resident had a focus for behavior problems related to resistance to care and wandering and impaired cognitive function/dementia or impaired thought processes related to short and long-term memory loss and dementia. Interventions included administer meds as ordered, intervening as necessary to protect the rights and safety of others. Approach and speak in a calm manner, divert attention, remove from situation and take to alternate location as needed. The quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 07, indicating severe cognitive impairment. Further review of the MDS revealed no indicators for mood or behaviors. The progress notes dated April 19, 2024 documented an incident note that revealed CNA reported that resident #1 was struck by another resident and that the patients were separated from each other. The note further states resident #1 had no marks on her and denied pain. Appropriate staff and providers notified of the incident. The provider notes dated April 20, 2024 revealed resident #1 reported no complaints of right shoulder pain due to being punched by a resident. Per the provider note staff were to monitor pain and level of consciousness (LOC). -Resident #2 was admitted to the facility March 14, 2016 with diagnosis including dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, major depressive disorder, recurrent, mild. A care plan initiated in April 2024 revealed the resident had a focus for use of mood stabilizer medication (Depakote) r/t dementia with behaviors and potential to demonstrate physical behaviors hitting others r/t Anger, Dementia, Poor impulse control, physical behaviors. Interventions included to Give mood stabilizer medications ordered by physician. Monitor/document side effects and effectiveness, target symptoms/Behavior Tracking:(mood swings) and Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. (continued on next page)

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	035233	A. Building B. Wing	12/06/2024

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Haven of Globe	1100 Monroe Street Globe, AZ 85501

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 99 indicating resident was unable to complete the interview. Further review of the MDS revealed a diagnosis for dementia with no indicators for behaviors. The progress notes dated April 19, 2024 revealed resident #2 struck another resident after she bumped his wheelchair while ambulating and attempting to pass resident #2 who was seated in his wheelchair in the hallway. The note states that resident #2 struck the resident on her left arm and that both residents were immediately separated while resident was assessed for injuries. A physician note dated April 20, 2024 revealed resident was seen for being aggressive. The note revealed resident did not recall his punching on one of the residents. The note further documents increasing aggressive behavior. Review of the facility investigation with discover date of April 19, 2024 included that both resident #1 and #2 were interviewed. Per the documentation, resident #1 stated when asked how she was doing that she was a little sore. When asked what happened resident #1 stated I got bucked off a horse, but I am doing better. Resident #2 was interviewed and when asked how he was doing resident #2 stated yeah. Resident #2 was asked if he had any run-in with another resident, resident #2 laughed and stated no, no, no. Continued review of the facility investigation included that the facility identified this incident was unsubstantiated due to the fact that there was no willful intent to cause harm from either of the residents and that both residents are wandering risk, impaired thought process, and unaware of own safety needs. An observation was conducted December 6, 2024 at 3: 26 p.m. of the behavioral unit where both residents #1 and #2 reside. Observed both resident's in the dining area with other unidentified residents unsupervised. No staff present. This surveyor continued observation of the residents. Two staff later identified as certified nursing assistant (Staff#61/CNA) and Activities Manager (Staff #10/Activities) walked by at 3:31 p. m. An interview was conducted on December 6, 2024 at 3: 32 p.m. with Activities Manager (Staff #10/Activities) Staff #10 stated she had provided activities on the unit and had left the unit at 2:00 p. m. Staff #10 stated the residents were left in the dining room and that the staff were somewhere on the unit. An interview was conducted on December 6, 2024 at 3:33 p.m. with (Staff#61/CNA). Staff #61 stated she had taken the CNA course at the facility and was a [NAME] for the facility prior to that. She stated the staff receive report every morning for any resident that needs an extra eye on them and to keep them close to us and to keep staff on the unit. Staff #61 stated she was unaware of any altercations with any of the residents currently in the dining area. Staff #61 stated she was unaware of the incident with resident #1 and #2 and they should not be left alone unsupervised. Staff #61 stated if there was an altercation with any of the residents she is to de-escalate the situation - remove the residents and report the incident. Staff #61 stated the residents #1 and #2 had been left alone approximately 20 minutes while she provided care for another resident that required the assist of two. Staff #61 stated residents who had a prior altercation require supervision and monitoring because they are a high risk- staff #61 further stated the risk of not supervising or monitoring those residents can be cause for recurrent incidents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER Haven of Globe		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 Monroe Street Globe, AZ 85501	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on December 6, 2024 at 4:12 p.m. with (Staff#12/LPN) Staff # 12 stated he could not recall the incident but the information he documented in the progress note is correct. Staff #12 stated resident #2 has behavior issues he likes his space becomes verbally aggressive and tries to intimidate the other residents. Staff #12 stated resident #2 should not be left alone unsupervised, not monitored with other residents. Staff #12 stated there are two CNA's on the unit plus a nurse. Staff #12 stated it is difficult to monitor the residents when he is down the hallway or outside of the unit passing medications. Staff #12 stated there is not enough staff on the unit to supervise and monitor the residents, given that some of the residents require two people to provide their care. Staff #12 stated the risk of leaving residents on the unit unsupervised or monitored is they can become verbally and physically aggressive. Regarding residents #3 and #4: -Resident #3 was admitted to the facility September 16, 2020 with diagnosis including unspecified dementia, unspecified severity, with mood disturbance, unspecified dementia, unspecified severity, with other behavioral disturbance, major depressive disorder, recurrent, unspecified. A care plan initiated in April 2024 had a focus for impaired cognitive function/dementia or impaired thought processes r/t short term memory loss, dementia and at risk for misappropriation, neglect, abuse, and/or exploitation related to dementia, resides in wandering unit, physical aggression received from another resident. Interventions included provide with compatible staff whenever possible, separate resident from an aggressor, administer meds as ordered. The quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 05 indicating severe cognitive impairment with no indicators for behaviors or mood. An alert charting note dated March 1, 2024 for change of condition summary revealed the following documentation; At approximately 1210 while passing noon medications, I heard resident #3 as she was seated to her usual dining table talking loudly, I looked over and saw resident #4 standing behind her wheelchair tugging at the handle trying to pull it backwards. resident #3 continues to state, leave me alone, stop it, don't do that. I then proceeded to walk towards the two resident's when resident #3 tells resident #4 to leave her alone, is when I witnessed him bend down, push his left forearm into her neck, and punched resident #3 twice in the right shoulder arm and proceeded to hit her in the face when I placed my hands on his chest and grabbed both arms to block his arm and held his chest to place space between resident #4 and resident #3 , resident #4 stumbled backwards, where I was able to get resident #3 away when the other CNA's in the Unit came to assist with getting resident #4 out of the dining room. Incident was reported to DON, Charge Nurse and Administrator. Resident #3 was visibly and emotionally upset and distraught by the incident, resident #4 was removed and redirected down the hall by CNA's in the unit. Resident #3 was assessed and taken back to her room. Resident #3 was assessed, did not have any bruising noted to her right upper arm, shoulder or face. No cuts or open areas to her body. Resident #3 vital signs are stable. Review of the physician progress note dated March 2, 2024 stated reason for visit - resident got hit by a male resident and complained of shoulder pain with a recommendation for Voltaren for symptom management. (continued on next page)

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Haven of Globe	1100 Monroe Street Globe, AZ 85501

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility investigation with discover date of March 1, 2024 included that both resident #3 and #4 were interviewed. Resident #3 reported that she was sitting in the dining room at the table and a man came to her and started tugging on her wheelchair, she stated stop, don't do that and resident #3 stated he reached down trying to mess with the brakes then she reached down with her hand to stop him and when she did he leaned into her and punched her twice in the right upper arm she stated after the incident she went straight to her room. An attempt was made to interview resident #4 but revealed resident cognitively understand and continued to wander away from the interviewers. Additional review of the facility investigation revealed a witness statement dated March 1, 2024. Witness states he observed the incident from 20-25 ft. The statement details resident #4 initially circled resident #4 and became verbally loud while standing above resident #3. The witness states resident #3 became frightened and raised her voice asking resident #4 to get away from her. Resident #4 then placed his forearm in a blocking fashion against her neck and pushed. The witness states resident #3 became extremely frightened and became louder when resident #4 proceeded to cuss and 'landed 2-3 punches about resident #3 upper body. The witness states staff separated resident # 3 by removing her from the dining room and that resident #4 remained in a defensive mode for the next 15 minutes or more. A telephonic interview was conducted on December 6, 2024 at 1:36 p.m. with registered nurse (Staff #30/RN). Staff # 30 had provided a previous interview regarding another incident in the facility. Staff # 30 stated she could not continue with the interview as she was on vacation and her family was waiting on her, but that everything is documented in my nursing note, I saw resident #4 hit resident #3 multiple times. An interview was conducted on December 6, 2024 at 3:33 p.m. with (Staff #61/CNA). Staff #61 stated she had taken the CNA course at the facility and was a [NAME] for the facility prior to that. She stated the staff receive report every morning for any resident that needs an extra eye on them and to keep them close to us and to keep staff on the unit. Staff #61 stated she was unaware of any altercations with any of the residents currently in the dining area. Staff #61 stated she was unaware of the incident with resident #1 and #2 and they should not be left alone unsupervised. Staff #61 stated if there was an altercation with any of the residents she is to de-escalate the situation - remove the residents and report the incident. Staff #61 stated the residents #1 and #2 had been left alone approximately 20 minutes while she provided care for another resident that required the assist of two. Staff #61 stated residents who had a prior altercation require supervision and monitoring because they are a high risk- staff #61 further stated the risk of not supervising or monitoring those residents can be cause for recurrent incidents. An interview was conducted on December 6, 2024 at 3:58 p.m. with Director of Nursing (DON/staff #43) stated staff are informed during report about resident incidents and any supervision or monitoring needed. Residents should be observed for escalation of any behaviors and remove from the situation. The DON stated the risks associated with not providing supervision is verbal or physical aggression and feel there is sufficient staff to provide these preventative measures. Review of the facility policy titled Resident Safety: Safety and Supervision of Residents states Our 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.

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NAME OF PROVIDER OR SUPPLIER Haven of Globe		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 Monroe Street Globe, AZ 85501	

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910 Based on clinical record review, staff interviews, and review of facility policies, the facility failed to ensure oxygen was administered as ordered by the physician for one of 3 sampled residents (#21). The deficient practice could result in residents not receiving adequate oxygen to prevent hypoxia. Findings include: Resident #21 was admitted on [DATE] and discharged [DATE] with diagnoses chronic obstructive pulmonary disease, unspecified, unspecified asthma, uncomplicated, dependence on supplemental oxygen, chronic respiratory failure with hypoxia, unspecified symptoms and signs involving cognitive functions and awareness, legal blindness, as defined in USA). Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 8, indicating resident's cognitive status moderately impaired. Further review of the MDS revealed resident receiving oxygen therapy. Review of the Care Plan date-initiated March 3, 2023 revealed resident receiving oxygen therapy related to Chronic Obstructive Pulmonary Disease (COPD). Interventions included when eating, oxygen must still be given to the resident but in a different manner (e.g., changing from mask to nasal cannula). Return resident to usual oxygen delivery method after the meal and monitor for signs and symptoms of respiratory distress. A physician's order dated March 8, 2023 included an order for oxygen at 3 liters per minute as needed to keep saturation level above 90%. every shift for Oxygen Therapy A physician's order dated September 20, 2023 included an order for oxygen at 3 liters per minute via NC. May titrate as needed to keep saturation lever greater than 90%. every shift for oxygen therapy. A physician's order dated November 20, 2023 included an order for oxygen at 1-5 liters per minute as needed to keep saturation level above 90%. every shift for oxygen therapy related to chronic obstructive pulmonary disease, unspecified (j44.9) This order was transcribed onto the MAR (medication administration record) for November 2024 and revealed that the resident had O2 sat levels of greater than 90% at 2 liters per minute. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER Haven of Globe		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 Monroe Street Globe, AZ 85501	

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing progress note dated November 23, 2024 revealed that CNA (Certified Nursing Assistant) was being taking resident #21 to breakfast, when stopped by another CNA due to resident being slumped over in her wheelchair and leaning to the left side. This nurse was called to the 500 hallway by CNA who informed resident did not have her oxygen on, breathing was labored and uneven. VS (vital stats) were taken, Resident #21 VS: 172/74, P-122, R-22, T-98.9, oxygen was at 57% RA. Resident's eyes were glassy and watery, resident's breathing was labored, oxygen VI simple mask was placed on resident with oxygen turned on to 10 L. Resident was noncoherent, speech was garbled and breathing continues to be labored, resident was taken to her room, assisted by two CNA's into bed, oxygen turned on and VS continued to monitor, called 911 for transport to hospital. Further review of the progress notes revealed an entry dated 11/21/2024 by the provider. The note states resident #21 was seen due to shortness of breath with exertion during therapy oxygen in use and noting last labs were done in June with noted hyponatremia, and elevated A1C- rechecking bmp. The hospital history and physical note for visit date of November 23, 2024 included that the resident respiratory exam findings- no respiratory distress, unremarkable stable chest x-ray, Hyponatremia (chronic), hyperkalemia diagnosis, likely UTI- at baseline 2 L O2- Pt required 4 L and BiPAP-repeat chest x-ray showed pulmonary edema bilaterally. 11/24/24- Pt transferred by air to Banner Glendale. A telephonic interview was conducted on December 6, 2024 at 1:28 p.m. with the registered nurse (RN/staff #30) who stated the certified nursing assistant (CNA) was bringing the resident out of the room approximately 20 ft from her room when she had noticed the resident was leaning and told the CNA to make sure resident has O2. Staff #30 stated the resident did not have the nasal cannula or oxygen on her, the CNA had the cannula it in her hand. Staff #30 stated she informed the CNA that the resident needed the oxygen hooked up to her now, on three liters. Staff #30 stated the resident was leaning to her left side when the CNA proceeded to take the resident to the dining room. Staff #30 state she did not see the residents face nor did she assess the resident. Staff #30 stated the resident was up at 4:45 a.m. and when she started her shift the resident was in her wheelchair, but was unsure if the resident had her oxygen on or when they got the resident up. Staff #30 stated when she asked the CNA to administer the resident oxygen that the resident's cannula was in her nose but was unhooked from the E tank with the tubing in the NA's hand. Staff #30 stated the CNA is responsible for changing out the tanks the NA was not certified at the time and was working with a CNA that was training her. Staff #30 stated the NA and resident #21 did not make it to the dining room and was observed by another nurse who asked if staff #30 had looked at the resident. Staff #30 stated when she observe the resident the resident was leaning, lethargic and mumbling when her head fell forward. Staff #30 stated she took resident #21 vital signs revealing a high blood pressure and saturation levels at 57. Resident #21 was taken back to her room and administer 5 liters of oxygen elevated head, O2 went up to 92% and called emergency services. An interview was conducted on December 6, 2024 at 3:10 p.m. with Licensed Practical Nurse (Staff #15/LPN) who stated the signs of symptoms of hypoxia are shortness of breath, confusion, cyanotic lips and fingertips. Staff #15 stated CNA's can place the resident oxygen and tubing, but it is the responsibility of the nurse in ensuring the residents oxygen is on at the right liters per minute (LPN). Staff #15 stated CNA's are to ask the nurse what the orders are for the resident's oxygen levels. Staff #15 stated the nurse is responsible to make sure the right mask or cannula are used and that CNA's do not have the qualifications to place oxygen on a resident and would need to test for it. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Certified nursing assistant (Staff #61/CNA) on December 6, 2024 at 3:33 p. m. Staff #61 stated the responsibilities as a CNA for residents with oxygen, is to make sure tank is full, that the resident is plugged in on their concentrator, always check their vitals, switch from concentrator to the tank, check with the nurse to adjust the oxygen level and that a CNA is not allowed to change or administer oxygen to residents. An interview was conducted with the Director of Nursing (Staff #43/DON) on December 6, 2024 at 3:58 p.m. Staff #43 stated both RN's and LPN's are responsible for administering and ensuring the correct LPN's are being administered and that the nurse should be present and assessing the resident. Staff #43 stated it is her expectation that the nurse call for services, transfer for appropriate services and that the nurse should have stopped the NA and assessed the resident and sent back to their room instead of proceeding to the dining room. The DON further stated it was inexcusable for the nurse to state that she did not see the residents face. The DON stated NA's are not allowed to administer oxygen and the risks of not administering oxygen as ordered could lead to patient decline or death. A review of the facility's policy's titled Respiratory/Pulmonary Conditions: Oxygen Administration state; 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 7. Check the tubing connected to the oxygen cylinder to assure that it is free of kinks. 8. Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute. 9. Place appropriate oxygen device on the resident (i.e., mask, nasal cannula and/or nasal catheter). 10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. 11. Securely anchor the tubing so that it does not rub or irritate the resident's nose, behind the A review of the facility's policy's titled - Medications: Administering Medications Policy Statement Medications are administered in a safe and timely manner, and as prescribed. 1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. Medications are administered in a safe and timely manner, and as prescribed.