STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035240	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Lake Havasu	2781 Osborne Drive Lake Havasu City, AZ 86406

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** 49199 Based on record review, interviews and facility documentation and policy, the facility failed to ensure one resident (#1) was free from abuse from a staff member. The deficient practice could lead to further abuse of residents. Findings include: Resident #1 was admitted to the facility on [DATE] with a diagnosis of acute and chronic respiratory failure with hypoxia and hypercapnia, wedge compression fracture of first lumbar vertebra, history of falls, and low back pain. Review of the most recent MDS (Minimum Data Set) dated April 16, 2024 revealed a BIMS (Brief Interview for Mental Status) score of 06, which indicated severe cognitive impairment. The facility reportable event record/ report stated that on January 6, 2024 it was reported to the administrator that registry aide (staff #5) was being unkind. The report stated after resident #1 refused shower and in attempt to give bed bath, staff #8 witnessed staff #5, with a wet cloth on her hand spun around, causing water to splash all over resident's #1 face. The report further stated the resident #1 told staff #5 that she got water all over her, to which staff #5 replied she meant to do that as the resident was getting bed bath. The report stated staff #8 cleaned resident #1 and remained by bedside throughout the remainder of bed bath without further incident. Staff #8 then reported it to the charge nurse and charge nurse reported it to the administrator. The report stated staff #5 was sent home immediately. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 June 11, 2024 at 09:55 AM with Staff #8, CNA (Certified Nursing Assistant) to recall the events that took place on January 6, 2024. Staff #8 stated that Staff #5, CNA, went into Resident #1's room to give her a shower. Staff #5 wanted to put Resident #1 in the hoyer lift to get her into the shower, but Resident #1 stated that she hurt too much and did not want to get into the shower. Staff #8 stated that Staff #5 said That's gross, you need to take a shower to the resident #1. She stated resident#1 then requested bed bath. Staff #8 stated she told Staff #5 that it was resident's right to refuse a shower so a bed bath can be provided. Staff #8 stated when a bed bath is given, a basin with warm water, a washcloth and soap is used. Staff #8 stated that Staff #5 put the washcloth in the basin of water and put soap on it, then staff #5 did not wring the washcloth out, held and moved the washcloth over Resident #1 face, dripping water all over the resident's face. Resident #1 stated hey, you soaked me to which Staff #5 stated I meant to do that. Staff #8 stated she tried to smooth the situation by saying that staff #5 did not mean to do that and she was sorry. She stated she cleaned the water off the resident's face and that both staff members finished the bed bath. Staff #5 left the room with the dirty linens and Staff #8 stated that Resident #1 said to her I am so happy you were a witness to that, I don't trust her and I want it reported, to which Staff #8 replied she will be reporting it immediately. Staff #8 stated that she notified the charge nurse and she remembers Staff #5 being escorted out of the building around suppertime. An interview was conducted on June 11, 2024 at 10:30 AM with the DON (Director of Nursing/ Staff #10). When asked if she remembered the events of of January 6, 2024 between Resident #1 and Staff #5, she stated she did not remember but she remembered Staff #5 was escorted out of the building and the facility notifed staff #5's recruiter. She stated the facility canceled staff#5's contract. When asked if the facility reported to the Licensing Board and Staff #10 replied no. An interview was conducted on June 11, 2024 at 10:37 AM with LPN (Licensed Practical Nurse/ Staff #7). She stated that on the morning of January 6, 2024, she discovered Staff #5 did not put a resident's nasal cannula back on, causing the resident oxygen saturations to drop to 89%. Staff #7 stated she told the charge nurse (Staff #2) of what had happened and Staff #2 spoke with Staff #5 and educated her on what to do when a resident is on oxygen. An interview was conducted on June 11, 2024 at 10:56 AM with the Administrator (Staff # 4). Staff #4 stated she did not substantiate this incident because when she interviewed Staff #5, she stated that it was an accident and apologized for it. She also stated she knew she had eye witness statements that the incident did occur but she said she could not be sure. Review of the facilities policy on Abuse, dated 2022, statesif the abuser is an employee, they will undergo immediate termination and licensure reporting as applicable.