STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035240	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2024
NAME OF PROVIDER OR SUPPLIER: Haven of Lake Havasu		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42319 Based on clinical record review, staff interviews, and review of policy and procedures, the facility failed to ensure discharge planning included developing a discharge care plan for one sampled resident (#80). The deficient practice resulted in an ineffective transition to post-discharge care, and increases the risk factors leading to preventable readmission. Findings include: Resident #8 was admitted on [DATE] with diagnoses that included rhabdomyolysis, pressure-induced deep tissue damage of the sacral region, unstageable pressure ulcer of left buttock, and unstageable pressure ulcer of right buttock. An Admission Evaluation -Nursing assessment dated [DATE] revealed the resident's expectation at admission was to be discharged to the community. Review of the comprehensive care plan dated June 28, 2024, revealed an appropriate pre-discharge plan will be established by coordinating discharge plans with the Interdisciplinary Team (IDT), and helping to provide services according to care plan in an effort to enhance optimum well-being. This care plan included that a pressure ulcer was noted on admission. A physician's order dated July 5, 2024 included cleanse dissipated blister to mid lower back with NS pat dry apply Medi honey, apply calcium alginate and cover with dry dressing daily until healed every day shift A physician's order dated July 19, 2024 included cleanse unstageable to left buttock with wound cleanser pat dry apply collagen apply calcium alginate cover with dry dressing daily until healed every day shift related to PRESSURE ULCER OF LEFT BUTTOCK, UNSTAGEABLE. A physician's order dated June 29, 2024 included Apply [NAME] all-body powder to abdominal folds for moisture control. The Admission Assessment Minimum Data Set (MDS) assessment dated [DATE] included that this resident was not cognitively impaired and that this resident required substantial/maximal assist for lower body dressing, rolling right to left, sitting to lying and chair to bed transfers, and was dependent for toilet hygiene. (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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A health status progress note dated August 1, 2024 revealed that Resident and son voiced concern regarding insurance and discharge, both were very noticeably unset, writer left a message for social worker and writer went to find speak with DON and she was not available, writer went to administrator and she went to resident room and spoke with family and gave them options and information that they were thankful for, both were both noticeably feeling better and writer witnessed son making phone calls. A daily skilled evaluation progress note dated August 2, 2024 revealed that wound care was provided and that the resident visibly upset and tearful during assessment due to possible discharge home tomorrow, she states she is not ready to go home and worries about her condition as she cannot dress her wounds by herself. Comfort and encouragement provided by RN Wound treatments being done daily and PRN due to area of dressings. Wounds are improving but still open in multiple areas. A Discharge summary dated August 2, 2024 included 8/2/2024 that the resident was discharged to a private home/apartment with home health services to be provided. A Discharge and Transfer assessment dated [DATE] included that the resident was being discharged to the community and that the facility IDT and/or managed care initiated the discharge. This document included that [NAME] would be providing the home health and that Preferred Home Care was providing a wheelchair. This document included to: cleanse unstageable to left buttock with wound cleanser pat dry apply collagen apply calcium alginate cover with dry dressing daily until healed, cleanse dissipated blister to mid lower back with NS pat dry apply Media honey, apply calcium alginate and cover with dry dressing daily until healed and Apply [NAME] all-body powder to abdominal folds for moisture control. This document also included that this resident requires substantial/maximal assistance with toileting hygiene. The Discharge return not anticipated Minimum Data Set (MDS) assessment dated [DATE] included that this was a planned discharge. However, an interview was conducted on August 19, 2024 at 2:53 with a staff member at [NAME] Home Health Agency, who stated that they did get the referral for this resident but that they did not provide services because they are not serviced by this resident's insurance. A complaint received on August 12, 2024 included that a patient was sent home with unstageable pressure ulcer, no medications, and no one to do wound change at home. This allegation included that the resident had severe yeast infection under both breast as she had not been being washed properly, that this resident was never taken to wound care center for proper treatment of wound and that the resident's family was refusing to do wound care and patient was taping napkins to the buttock. This complaint alleged that this was an inappropriate discharge. An interview was conducted on August 19, 2024 at 3:02 P.M. with resident #8 who said that the facility was to set up home health, had one person come out and they found out did not work with insurance without a primary doctor, then she had to get to primary doctor, and that tomorrow she was going to a wound care center. She said that the day after discharge that she went to the hospital because the wounds opened up, they referred us to wound care to see if I still require attendance. I had to go to the emergency to get my wounds cared for. She said that the facility did not train her family member on her care as her family members would never change her dressings. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on August 19, 2024 at 3:02 P.M. with resident #8's family member who said that they were not trained in wound care. This family member said that the facility filed for home health care but that it took over a week because they kept filing with people who did not accept her insurance. He said that the home health took a week to get there and do a wound dressing then told resident #8 she need a referral from a primary or an action plan form wound care or maybe both before they could continue with services. This family member said that this home health worker said that the wound was a lot worse than she was told and that it looked like haven hadn't taken care of it at all. This family member stated that he had called the facility multiple times trying to figure out the home health and that the resident never got the wheelchair from Preferred, because Preferred never got any paperwork for her. An interview was conducted on August 20, 2024 at 10:45 A.M. with the Resident relations manager (staff #27) who said that she talked about discharges with residents as soon as they arrive, and that weekly they have an Interdisciplinary team meeting and discuss who will be discharged in the next 7 days and when they discharge what services they will need, then get them a NOMNC (Notice of Medicare Non Coverage) and explain right to appeal, then set up home health. This staff said most people who discharge is through [NAME] but that it takes time to get and that there is 1 company for durable medical equipment available in the area and they put a hinder on discharge. This staff said that they let residents go home with our wheelchairs. This staff said that if they cannot get them services because insurance is not covering the required services, we give them orders for outpatient care or sometimes have to let them know that insurance does not cover service in the area. This staff said that for this resident, she got a NOMNC, and appealed and then lost the appeal and that the resident was discharged on a Saturday. She said that the staff ordered her a wheelchair but that she did not know if she got the the wheelchair. She said that wound care was set up through [NAME] and that the staff had received a notification that home health not covered insurance. She said that the staff only had 2 days to set up services. She said that she next sent the referral to Family Home Care. She said that this resident discharged on Saturday, that she was told that on Sunday the family called and they said that home health was not going to come on Sunday and help was needed with wound care and that the charge nurse told the family member to go to emergency room . This staff confirmed that they do not routinely check to see if residents have durable medical equipment once they have discharged . An interview was conducted on August 20, 2024 at 12:08 P.M. with the Director of Nursing (DON/staff #65) who said that if a resident has an order, the resident should receive the order the same day, and going forward they should receive the treatment as ordered. This staff said that a resident can be discharged if they are able to go home safely, if they are at their baseline, family, if they have support and equipment they need when they get home. A policy titled Admissions/Transfers/Discharges: Transfer or Discharge- Preparing a Resident for discharge date d January 1, 2024 revealed Nursing services is responsible for obtaining orders for discharge or transfer, as well as the recommended discharge services and equipment.