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	10/17/2024

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 - 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 reviews, staff interviews, and policy review, the facility failed to ensure one resident (#135) was free from self-harm following an encounter of self-reported suicidal ideation. The deficient practice could result in further neglect, harm or possible death of residents. Findings include: Resident #135 was admitted to the facility on [DATE], with diagnoses that included major depressive disorder, recurrent, unspecified, anxiety disorder, unspecified. Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status was conducted which revealed a BIMS score of 14, indicating resident's cognition was intact. Further review of the MDS section D for mood assessment revealed a severity score of 23. The score indicated resident was feeling down, depressed or hopeless. Additionally, trouble falling or staying asleep or sleeping too much, feeling tired or having little energy; Poor appetite, feeling bad about herself or that she is a failure or have let the family down; having trouble concentrating on things. These thoughts and feelings occurred nearly every day. Resident had thoughts that she would be better off dead or of hurting herself in some way. These thoughts occurred one day. Review of the psychiatric provider follow-up assessment progress note dated September 24, 2024 with time of 12:45 PM revealed that the resident reported that she, is not doing well and also reported, tired of living and weaker than ever. Further review of the psychiatric note revealed, suicidal ideations including resident reporting she, is ready to go and was having suicidal ideations with a plan to overdose on pills, if I could. Resident also reported a poor appetite with a lot of sleeping. This encounter was signed and dated by the psychiatric provider following the consultation. Review of the care plan and progress notes revealed no evidence that the facility acted upon the psychiatric follow-up assessment progress note dated September 24, 2024. (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 0600 Level of Harm - Actual harm Residents Affected - Few	The care-plan initiated on August 26, 2024 revealed that the resident had a mood problem related to depression. The goal was resident will have improved mood state, and no sign or symptoms of depression through the review date. Interventions included -- observe/monitor/record/report to medical doctor as needed risk for harm to self or others: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, sense of hopelessness or helplessness; possession of weapons or objects that could be used as weapons. Physician orders dated September 27, 2024, revealed an order for Sertraline tablet 25 milligrams Give 1 tablet by mouth one time a day for depression related to major depressive disorder, recurrent, unspecified. Review of the behavioral tracking for anxiety and depression in the medication administration record for October 1-8, 2024 revealed no identified changes in mood had been documented for resident #135. Medical record review revealed progress note dated October 8, 2024 at 05:15 AM resident was transferred via ambulance; responsible party notified; physician notified; DON notified; executive director notified; details of occurence leading to hospital transfer include: suicide ideation meausres taken to stabilize resident prior to determination to transfer: 1:1 sitter head to toe assessment; wound on left wrist cleaned resident is alert and oriented. Review of the Hospital records dated October 8, 2024 revealed, patient has lacerations on her left wrist in an attempt to stop being a burden to her family. Pt was trying to kill herself. The hospital record revealed a note from Emergency Medical Services (EMS) stating, when triaging this patient, the patient mentioned that she did have a plan for suicide and that if she went home, her plan was to take pills. Further review of the hospital record revealed a Columbia Suicide Severity Rating Assessment was conducted revealing a high-risk score recommending a psychiatric consult and patient safety precautions. Questions regarding this assessment include: have you wished you were dead or wish you could go to sleep and not wake up? Past month YES. In the pas month have you had actual thoughts of killing yourself? YES. In the past month have you been thinking about how you might do this? YES. In the past month have you had these thoughts and had some intention of acting on them? YES. In the past month have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? YES. In the past 3 months have you ever done anything, started to do anything, or prepared to do anything to end your life? Yes. An interview with a Licensed Practical Nurse (LPN/staff #65) was conducted on October 17, 2024 at 4:31 p. m. The LPN indicated that for residents with suicidal ideations that it is important information for staff to have as it gives them a better picture of the residents needs and what to look out for. Staff #65 noted that the risk of a care plan not addressing specific issues such as suicidal ideations can affect the residents care if the care plan is not updated; and that, would not give nurses a clear picture of the current needs for the resident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with Certified Nursing Assistant (CNA/Staff #30) on October 17, 2024 at 5:04 p. m. Staff #30 stated she worked the night shift 3-4 days per week and was assigned resident #135 when she attempted to self-harm. Staff #30 stated she provided care or observed the resident every two hours. Staff #30 stated she went into the resident's room at approximately 5am to check for incontinence. She stated she woke the resident, using her flashlight and did not notice her arms at the time, but noticed dried blood on the resident's gown and fingers and thought she may have had a bloody nose. She stated she asked the resident where the blood had come from and the resident stated she had tried cutting herself with a knife from dinner because she felt she was a bother to her family and they were better off without her. Staff #30 stated the resident had not made any comments of self-harm or had been informed in report that this was of a concern. She stated that the resident was very calm regarding the matter of the incident. Staff #30 stated if this was a concern it would have been in the resident's care plan or given in report to monitor her for any ideas of hurting herself and immediately tell the nurse if a resident should voice any thoughts of self-harm. An interview was conducted with both the Director of Nursing (DON/staff #12) on October 17, 2024 at 5:46 p. m. The DON indicated that the residents care plan was not updated because the facility was unaware of the psych progress notes until the resident discharged to the hospital while gathering documents for the hospital. The DON stated if the facility were made aware of the resident's suicidal ideations, interventions would have been provided for the resident such as increased rounding, monitoring and changes to the care plan for staff. The DON stated, we don't read every single note and the psych provider did not share the information or concerns with the facility and should have. The DON stated they are in the process of revising their process regarding their communication with providers and reviewing any follow-up progress notes. Review of the facility policy titled, Abuse Policy dated 2022 (version 0622) revealed, faility strives to prevent the abuse of all their residents. By definition, abuse is the infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, neglect, mental abuse. Review of the facility policy titled, Behavior/mood/cognition: behavioral assessment, intervention and monitoring dated January 01, 2024 revealed, the facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The interdisciplinary team (IDT) will thoroughly evaluate new or changing behavioral symptoms in order to identify underlying causes and address any mondifiable factors that may have contributed to the resident's change in condition, including: emotion, psychiatric and/or psychological stressors (for example): depression; loneliness. The IDT will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm. If the resident is being treated for altered behavior or mood, the IDT will seek and document any improvements or worsening in the individual's behavior, mood, and function.