

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER Haven of Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 North Lockwood Drive Lakeside, AZ 85929	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581</p> <p>Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to protect the rights of two residents (#24 and #15) to be free abuse by residents (#6 and #34). The deficient practice could result in residents being physically and mentally harmed.</p> <p>Findings include:</p> <p>Regarding resident #24 and #6</p> <p>-Resident #24 was admitted to the facility on [DATE] with diagnoses of hemiplegia, unspecified affecting the right dominant side, major depressive disorder, anxiety, and schizoaffective disorder.</p> <p>A care plan dated July 12, 2021 revealed the resident had the potential to demonstrate physical and verbal behaviors (hitting and swearing, threatening) related to poor cognition and understanding of situations. Interventions included that when the resident becomes agitated, intervene before agitation escalates; guide away from the source of distress; engage calmly in conversation; and if the resident was aggressive, staff were to walk away, and approach later.</p> <p>The care plan dated January 28, 2022 revealed that the resident had a psychosocial well-being problem actually related to anxiety, ineffective coping, lack of acceptance to current condition, traumatic brain injury, schizophrenia, verbal and physical aggression; and that, the resident was involved in an altercation with a peer. Interventions included assistance/encouragement/support to identify problems that cannot be controlled, and assistance/supervision/support to identify precipitating factor(s) stressors.</p> <p>The minimum data set (MDS) assessment dated [DATE] did not include a brief interview for mental status (BIMS) score because the resident was not able to complete the interview.</p> <p>A progress note dated July 3, 2024 revealed the resident was watching television along with another resident. Per the documentation, staff asked another resident a question, but the other resident did not hear and what, what? It also included that resident #24 then quickly self-propelled himself over to the other resident and grabbed his hand; and that, the other resident tried to pull his hand away and then cocked his arm, but staff was able to intervene before the other resident was able to punch resident #24.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note dated July 6, 2024 revealed that resident #24 was getting angry at other residents and self-propelled himself numerous times in his wheelchair and was giving the other residents angry looks.</p> <p>Review of the clinical record revealed no documentation of the resident to resident altercation with resident #15 that occurred on September 10, 2024.</p> <p>Review of the weekly skin check and wound assessment dated [DATE] revealed that resident #24 had a slightly red left cheek and red left eye. Forty-five minutes later the red left cheek and eye were resolved.</p> <p>-Resident #6 was admitted to the facility on [DATE] with diagnoses of unspecified mood affective disorder, depression, post-traumatic stress disorder, hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side.</p> <p>The care plan dated July 16, 2024 revealed that the resident had a behavior problem related to physical behaviors, and inappropriate sexual comments. Interventions included for staff to intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention and remove from the situation and take to an alternate location as needed.</p> <p>The MDS assessment dated [DATE] included a BIMS score of 15 indicating the resident was cognitively intact.</p> <p>The progress note dated August 29, 2024 revealed that resident #6 was sitting in the dining room waiting for dinner to arrive when another resident walked into the dining room. Per the documentation, resident #6 told the other resident to get your skinny ass in a chair now, you are too difficult for everyone to deal with, f**k you.</p> <p>A progress note dated August 29, 2024 revealed that the resident was coming down the hallway after snack time. Per the documentation, resident #6 wheeled up to another resident and raised his fists like he was going to punch him and he also purposely bumped into the other resident's wheelchair. It also included that the CNA redirected both of the residents, and there were no further behaviors.</p> <p>A progress note dated September 2, 2024 revealed that resident #6 was leaving the dining room after lunch and ran his wheelchair into the wheelchair of another resident; and that, staff moved the other resident out of path and resident #6 returned to his room.</p> <p>A progress note dated September 11, 2024 revealed that during snack time, resident #6 was going by another resident (#24) in the hallway heading for the dining room. Per the documentation, resident asked the other resident (#24) if he was okay and the other resident responded loudly; and that, resident #6 punched the other resident (#24) on the left cheek of the face. It also included that the other resident (#24) angrily asked resident #6 why he hit resident #24 in the face; and that, resident #6 continued towards the dining room, while calling the other resident names. The documentation also included that resident #6 reported that he would break legs and knock another resident out. The charge nurse, Assistant Director of Nursing and the Director of Nursing were notified and the police were called.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the 5-day investigation dated September 15, 2024 revealed that on September 10, 2024 at approximately 2:30 p.m. resident #6 was rolling himself down the hall to the dining room for a scheduled snack time. Per the documentation, he stopped next to resident #24 who was sleeping and tapped him on the shoulder.; and that, both residents spoke to each other, but staff could not hear what was said. It also included that resident #6 reached out and hit the left cheek of resident #24; and that, both residents were put on 15 minute checks and the police were called.</p> <p>Regarding residents #34 and #15</p> <p>-Resident #34 was admitted to the facility on [DATE] with diagnoses of alcohol dependence with alcohol induced persisting dementia, delirium due to known physiological condition, and unspecified protein-calorie malnutrition.</p> <p>The care plan dated August 28, 2023 revealed that the resident had a behavior problem related to impaired cognitive function, physical behaviors, resistive to care, and verbal behavior. Interventions included to intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, remove from situation and take to alternative location as needed.</p> <p>The minimum data set (MDS) dated [DATE] included a BIMS score of 2 indicating resident had severe cognitive impairment.</p> <p>The progress note dated August 31, 2024 revealed that a resident approached the nurse and reported that resident #34 was mad because the resident greeted resident #34 good morning and while the other resident was watching television, resident #34 tried to swing at him.</p> <p>Review of the progress note dated September 10, 2024 revealed that a certified medication assistant (CMA) heard yelling in the television area and saw resident #15 bumped into the wheelchair of resident #34 who began yelling at resident #15 again. Per the documentation, the CMA saw that both residents had their fists raised at each other; and, the CMA separated the two residents and informed them that it was unnecessary to try and fight each other. It also included that the CMA informed resident #34 that resident #15 bumped into his wheelchair by accident; but that, resident #34 did not respond and returned to watching television.</p> <p>-Resident #15 was admitted to the facility on [DATE] with diagnoses of unspecified dementia without a behavioral disturbance, anemia, and difficulty walking.</p> <p>The MDS assessment dated [DATE] included a BIMS score of 6 indicating the resident had severe cognitive impairment.</p> <p>The care plan dated April 8, 2024 revealed that resident #15 had a behavior problem related to putting himself on the floor at times, physical, and verbal behaviors. Interventions included to intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, remove from situation and take to alternate location as needed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The progress note dated September 10, 2024 revealed that a certified medication assistant (CMA) heard yelling in the television area and saw resident #15 bumped into the wheelchair of resident #34 who began yelling at resident #15 again. Per the documentation, the CMA saw that both residents had their fists raised at each other; and, the CMA separated the two residents and informed them that it was unnecessary to try and fight each other. It also included that the CMA informed resident #34 that resident #15 bumped into his wheelchair by accident; but that, resident #34 did not respond and returned to watching television. The CMA then informed resident #15 to stay away from resident #34 to avoid any more problems.</p> <p>Review of the 5-day investigation dated September 18, 2024 revealed that on September 13, 2024 at approximately 3:45 p.m., resident #34 had an altercation with resident #15. The documentation included that resident #34 was carrying a doll around while in his wheelchair and resident #15 was giving him a hard time for doing so; and that, while both residents were in the common area watching television, resident #34 wheeled over to resident #15 and pushed resident #15 from behind causing resident #15 to fall out of his wheelchair and land on the ground.</p> <p>An interview conducted on September 30, 2024 at 1:45 p.m. with a CNA (CNA/staff #11), who stated that she has received training on abuse and learned that she was to prevent residents from abusing each other by ensuring that they were separated, supervision was provided, and putting the residents on 15-minute room checks for approximately 24 hours if there had been a verbal threat or an incident had occurred between residents. She stated that staff try to ensure that there was always a staff in the public areas to supervise the residents. The CNA also said that it is abuse if a resident was physically abusive to another resident and an altercation occurs. The CNA further stated that resident #6 was oriented times 4 and knew that staff were watching him.</p> <p>An interview was conducted on September 30, 2024 at 2:05 p.m. with a registered nurse (RN/staff #15) who stated that she had received training on abuse. She stated that there was not always a staff to monitor the hall and dining room area; and that, the residents have activities and snack time in the dining room, so the activity person can help with supervision. She stated that resident #6 had a diagnosis of dementia, was oriented and a bully; and that, resident #6 gave resident #24 a shiner.</p> <p>An interview was conducted on October 1, 2024 at 9:19 a.m. with the Director of Nursing (DON/staff #1), who stated that all staff were required to attend abuse training and there are different types of abuse: physical, verbal, sexual, psychological, financial, and neglect. He stated that there was a staff assigned to supervising the common areas.</p> <p>A facility policy, Abuse Policy states that the facility strives to prevent the abuse of all their residents. The facility recognizes that they care for residents with a diagnosis of dementia and other mental illnesses whose behaviors are not always predictable. The facility further recognizes 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.</p>		