

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 02/06/2025
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** 50166</p> <p>Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure one of three sampled residents (#1) was not abused by another resident (#2). The deficient practice could result in residents being physically and emotionally harmed.</p> <p>Findings Include:</p> <p>-Regarding Resident #1:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses that included traumatic subdural hemorrhage without loss of consciousness, metabolic encephalopathy, dementia, delirium, depression, and anxiety.</p> <p>The OBRA (Omnibus Budget Reconciliation Act) Admission Minimum Data Set (MDS) assessment dated [DATE], revealed that the resident's Brief Interview for Mental Status (BIMS) score was 99, which indicated severe cognitive impairment. The assessment also revealed that the resident was exhibiting behavioral symptoms including physical and verbal on one to three days, and utilized a wheelchair and walker for mobility.</p> <p>A skin assessment dated [DATE], revealed that there was a resident to resident incident and there were no open areas or bruising to the site.</p> <p>A weekly skin assessment dated [DATE], revealed no evidence of bruising or wounds to the legs.</p> <p>Review of progress notes dated January 18, 2025 revealed no evidence of the altercation between Resident #1 and Resident #2.</p> <p>Review of the care plan revealed no evidence of the behaviors or altercation that occurred on January 18, 2025.</p> <p>A weekly skin assessment dated [DATE], revealed no evidence of bruising or wounds to the legs.</p> <p>-Regarding Resident #2:</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>Resident #2 was admitted to the facility on [DATE] with diagnoses that included alcohol abuse withdrawal, delirium, alcohol-induced dementia, and type two diabetes.</p> <p>The OBRA Admission assessment dated [DATE] revealed that the resident's BIMS score was 04, which indicated severe cognitive impairment. The assessment also revealed that the resident was not exhibiting behavioral symptoms.</p> <p>A behavioral care plan initiated January 17, 2025 revealed that Resident #2 exhibited verbal aggression and physical posturing towards staff and peers, and that staff should direct his attention away, make sure he was not within arm's length of his peers, or encourage him to go to his room to calm down. The care plan revealed resident #2 was less likely to physically hit someone, but rather it was a warning that he would.</p> <p>A behavior progress note dated January 18, 2025 revealed Resident #2 got upset because his roommate took a shower and thought that Resident #1 took his shaving stuff. Resident #2 went up to Resident #1 and kicked him in his legs. The progress note revealed that staff redirected Resident #2 away from his roommate.</p> <p>A weekly skin assessment was conducted on January 18, 2025 and it revealed no evidence of new skin issues or injury.</p> <p>Review of the facility investigation and reportable event record January 18, 2025 revealed that on January 18, 2025 at 4:45 p.m., Resident #2 was being escorted to his room in his wheelchair by staff when he stated you used my shaving cream to Resident #1.</p> <p>The facility investigation revealed that staff observed Resident #2 raise his foot and kick Resident #1 in the leg before staff intervened to move Resident #2 out of the room. It was revealed that staff immediately brought Resident #2 to the nurse ' s station to report the incident and a skin assessment was conducted for Resident #1, with no noted injuries. The facility investigation revealed that staff informed Resident #2 that personal care items were not kept in resident rooms and were provided by staff as needed. The residents were placed on 15-minute safety checks and were assigned to separate rooms for the night.</p> <p>Review of the care plan revealed no evidence of the behaviors or altercation that occurred on January 18, 2025.</p> <p>A behavior progress note dated January 19, 2025 revealed that the resident exhibited inappropriate sexual behaviors toward staff.</p> <p>A behavior progress notes dated January 27, 2025 revealed that Resident #2 pushed Resident #1 away from his room and Resident #2 blocked the room so he could not enter. The progress note revealed that staff removed Resident #1 and told him they would take him to the bathroom later.</p> <p>A behavior progress note dated February 1, 2025 at 12:35 p.m. revealed that during lunch, Resident #2 got upset with Resident #1 for getting in his space, and Resident #2 yelled and put his fists up. The progress note revealed that staff redirected Resident #1 away from Resident #2.</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>A behavior progress notes dated February 1, 2025 1:05 p.m. revealed that Resident #1 was passing by when Resident #2 yelled at Resident #1. The progress note revealed that staff redirected Resident #2 away from Resident #1.</p> <p>A behavior progress notes dated February 4, 2025 revealed that Resident #2 blocked the doorway to the room so that Resident #1 could not enter.</p> <p>An interview was conducted on February 6, 2024 at 1:28 p.m. with a Certified Nursing Assistant (CNA/Staff #256), who stated that she did not witness the altercation but she was at the nurse ' s station when it was reported. Staff #256 stated that Resident #1 did not have any behavioral changes following the altercation because he had dementia and so he was acting like he usually did. Staff #256 stated that Resident #2 ' s behavior prior to the incident was building up to it because Resident #1 would get up from his chair to go near Resident #2 and they would yell at each other. Staff #256 stated that Resident #2 had an issue with Resident #1, and they had other verbal altercations, some of which she reported, and they would chart them as behaviors.</p> <p>An interview was conducted on February 6, 2024 at 2:38 p.m. with a Registered Nurse (RN/Staff #158), who stated that the altercation was reported to him by the Certified Medication Aide (CMA/Staff #103). Staff #158 stated that neither of the patients exhibited any behavioral changes following the altercation, and that after the staff reported it to the Director of Nursing (DON/Staff#89), and he conducted a skin assessment on Resident #1 and charted the incident in a behavioral progress note. Staff #158 stated that he would only document the incident in the clinical record of the resident who physically harmed the other resident. Staff #158 stated that Resident #2 talked aggressively with everyone because it was the tone of his voice, and staff would give him a doll to make him less aggressive. Staff #158 stated that Resident #2 did not want anyone to go near him, and that he exhibited behaviors when other residents got too close. Staff #158 stated that the behavior was preventable as long as someone was always looking at Resident #2, but they were not doing a 1:1 with him.</p> <p>An interview was conducted on February 6, 2024 at 3:08 p.m. with a CMA, Staff #103, who stated that she witnessed the altercation between Resident #1 and Resident #2. Staff #103 stated that Resident #1 had a shower and then was sitting next to her medication cart when she heard Resident #2 wheeling his chair up next to Resident #1 and he said did you take a shower? You took my shaver. Staff #103 stated that residents do not have access razors or shavers so when she heard him say that, she immediately went to separate the residents but did not make it there in time, so she witnessed Resident #2 kick Resident #1 in the leg. Immediately following the incident, Staff #103 stated that she separated the residents and told the nurse, Staff #158, what had happened. Staff #103 stated that Staff #158 directed her to call the Executive Director (ED/Staff#207) but he did not answer so she contacted the DON, Staff #89. Staff #103 stated that leading up to the incident they knew Resident #2 was territorial and they would put Resident #2 into bed before putting Resident #1 to bed because if they didn ' t, Resident #2 might exhibit behaviors. Staff #103 stated that at the time of the altercation, neither resident made a noise and they did not really implement any interventions to prevent this from occurring again aside from keeping a close eye on Resident #2.</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>An interview was conducted on February 6, 2024 at 3:25 p.m. with the Director of Nursing, Staff #89, who stated that it was reported to him by the nurse, Staff #158, that Resident #2 kicked Resident #1 in the leg within 15 to 30 minutes of it happening. Staff #89 stated that the facility substantiated their investigation of the resident to resident altercation because there was an eye witness, and that police and other state agencies were not notified because it was not necessary. Staff #158 stated that the facility placed both residents on 15-minute checks, and a room change was not done at the time of the incident. Staff #89 stated that a recent prior incident involving an altercation between Resident #2 and another resident prompted the facility to initiate a behavioral program for Resident #2.</p> <p>An interview was conducted on February 6, 2024 at 3:36 p.m. with the Executive Director and Abuse Coordinator, Staff #207, who stated that he was notified of the altercation by the DON (Staff #89) shortly after it occurred. Staff #207 stated that he conducted his interviews the week after the incident occurred, and that the facility always followed the recommendations of the medical director who determined in this case that the facility should have revisited the residents care plans, conducted 15-minute checks for 24 hours on both residents, and that the residents should have slept in different rooms the night of the altercation. Staff #207 stated that the residents were roommates again the night after the incident, and the medical director told them the residents were okay to be roommates again because the residents did not have issues with one another the day after the altercation. Staff #207 stated that the results of the investigation were emailed to the Arizona Department of Health Services, and the ombudsman, local law enforcement, and Adult Protective Services were notified of the altercation.</p> <p>Review of the policy titled, Abuse Policy, revealed that abuse of any type, including verbal, sexual, physical, neglect, and mental abuse are not condoned, and residents have a right to be free from abuse. The policy also revealed that prompt reporting and investigating would be utilized to identify and implement measures to deter further incidents of abuse.</p>		