STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035277	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Lakeside	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)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on interviews, review of facility documentation, and review of policy and procedures, the facility failed to implement their policy to report and investigate allegations of neglect for one resident (#8) and failed to protect a reporter from retaliation. The deficient practice could result in allegations of neglect not being reported and investigated timely, which could result in continuing neglect. Findings include: Resident #8 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease, post-polio syndrome, chronic pain syndrome, asthma, and dyspnea. An admission minimum data set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview or Mental Status (BIMS) score of 15, indicating intact cognition. Additionally, Section E revealed that the resident had no potential indicators of psychosis, and no physical behavioral symptoms. A physician order dated February 12, 2025, at 10:58 AM, indicated to send Resident #8 to the emergency room (ER) for further evaluation of seizure like symptoms. An Alert Charting note dated February 12, 2025, at 11:09 AM, indicated that Resident #8 appears to be altered from baseline mentation with possible seizure activity. Physician notified and resident sent to the ER for evaluation. Emergency Medical Services (EMS) arrived at 11:09 AM, and the resident left the facility via ambulance at 11:15 AM. A therapy daily treatment note dated February 12, 2025, by a Certified Occupational Therapy Assistant (COTA /Staff #8), revealed that a co-treatment session for Resident #8 was completed with physical therapy. The note stated that Resident #8 was not very responsive that day, the COTA informed nursing and the provider, and communicated with the resident's sister who stated she has never seen her brother like that. The note further stated the resident was sent out to the emergency department via ambulance. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A therapy daily treatment note dated February 12, 2025, by a Physical Therapy Assistant (PTA / Staff #10), revealed a co-treatment of Resident #8 with a COTA to ensure patient safety due to a medical change. The note revealed the PTA indicated that the nurse needed to check on the resident due to a mental status change. The note stated the resident demonstrated increased confusion, difficulty with communication, oriented only to self, as well as dyskinetic movements followed by stilled body movements, blank expression, and lack of eye tracking. Nursing staff indicated that the resident is on medication for a urinary tract infection. The COTA informed the provider, and the provider indicated I will check on him in 5-10 minutes when I get down there. The PTA and COTA addressed other nursing staff and other nursing staff indicated the patient is faking, and is fine. The PTA discussed with the Director of Rehab (DOR) who continued to ask the facility staff to check and follow up on the resident. The PTA discussed the resident's status with the resident's family about what occurred during attempted therapy session. The resident was sent to the emergency department. An email dated February 14, 2025, from Resident #8's sister sent to the Director of Nursing (DON / Staff #95) and to the Assistant Director of Nursing (ADON / Staff #73), revealed that Resident #8 is now in the intensive care unit due to a severe infection from a urinary tract infection, and that she had communicated her concerns in previous emails on February 5 and 11, with no response from the facility staff. Additionally, the email revealed the resident's sister's concern that when she arrived to the facility on the morning of February 12, that there was a delay in the provider assessing the resident, and additionally the provider took more time to write at his desk before the resident was sent to the emergency room . The email revealed that then the resident's sister instructed the nurse to call 911 and not wait for the doctor's note, at which point the nurse then called 911. Additionally, the email revealed the resident's sister's allegation that the facility staff ignored (her) requests and alerts to (Resident #8's) condition that led to the resident being in the intensive care unit. Records from the discharging hospital revealed a physician note dated February 15, 2025, that Resident #8 was transferred to the hospital from another hospital for a higher level of care. Resident #8 was at a skilled nursing facility, had a urine culture that grew Enterobacter, and subsequently developed urosepsis and was sent to the emergency room . Resident #8 was found to be obtunded and hypotensive and transferred to the intensive care unit (ICU) for norepinephrine and fluid resuscitation, and was treated for acute kidney injury, possible seizure, and acute respiratory failure secondary to influenza A. On March 4, 2025, at 12:20 PM, a formal request was made to the facility for any text or email communication between facility staff and the contracted therapy company staff regarding any human resource (HR) issues for the PTA (Staff #10) as well as any supplemental training, corrective actions, disciplinary actions, and/or termination notice for Staff #10. The administrator (Staff #80) signed a statement that there was none. Additionally, a formal request was made to the facility for any policies on therapy documentation, the administrator signed a statement that there was no specific policy for therapy staff, that the facility follows the general policy Documentation: Charting and Documenting. Review of the contract between the PTA (Staff #10) and the facility's contracted therapy company revealed her assignment at the facility was initiated December 30, 2024, and was to end March 29, 2025. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on March 4, 2025, at 9:54 AM with a Certified Occupational Therapy Assistant (COTA / Staff #8). The COTA stated that if therapists were to notice a possible change in condition of a resident during a treatment session they would alert the nurse, check the resident's vitals, and possibly communicate with the provider. The COTA stated that the facility expects therapists to document the change of condition, to chart exactly what is going on and that nursing was informed, and to notify the Director of Rehab (DOR). The interview continued and the COTA stated in regard to Resident #8, that she noticed a big change in him on February 12, 2025. She stated prior to February 12, the resident was a little confused the whole time he was here, and that he had weird hand gestures. Normally, Resident #8 could converse with the therapists and follow directions. However, on the day of February 12, the COTA stated that she entered the resident's room around 9:00 AM. The resident was in bed, disoriented, and very different from any other day: he was unable to verbalize anything, could not follow any kind of direction, flailing his arms, randomly reaching places, and not oriented to himself, the time, or the place. Additionally, the COTA stated that during this therapy session on February 12, she was attempting to perform a co-treatment with a Physical Therapy Assistant (PTA / Staff #10), and that they both let the charge nurse (Staff #30) know about the resident's changes right away. The COTA stated that the nurse did not come to the resident's room to assess the resident, and the nurse responded by stating that this was typical behavior from Resident #8. The COTA stated she then re-iterated to the nurse that this was not typical behavior from the resident, and the nurse replied that this is typical behavior from the resident at night. She stated she did not proceed to assist Resident #8 out of bed because she was concerned about his status. The COTA stated that at that time, she also informed the DOR (Staff #20) what was going on with Resident #8, and that no staff came to assess the resident during the 10-15 minutes that she was in the room with the resident. The COTA stated that Resident #8's sister came in the middle of the attempted therapy session, and that the resident's sister stated that she was also very concerned with the resident's status and had tried to tell the facility staff of the change the prior evening on February 11. The COTA stated that she had to start treatments with her other scheduled patients but that she continued to go back to the room and check on Resident #8 several times, and that it was approximately 1 to 1.5 hours before EMS came to the facility for the resident. Further, the COTA stated that regarding the PTA (Staff #10), it seems like they fired her related to this incident, and that she's an excellent therapist and she advocates for her patients. An interview was conducted on March 4, 2025, at 10:17 AM, with a rehab tech (Staff #18). Staff #18 stated that on February 12, 2025, he passed by the resident's room and observed that the resident looked confused while working with the therapist. Additionally, Staff #18 stated that he witnessed a conversation between the PTA (Staff #10) and the nurse (Staff #30) where the PTA was expressing her concern about the resident to the nurse. Staff #18 stated that he passed by and did not hear the nurse's response. He additionally stated that in regard to Staff #10, I think she was let go, but could not specify why. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with an Occupational Therapist and Director of Rehab (DOR / Staff #20) on March 4, 2025, at 11:33 AM. The DOR stated that if therapists were to notice a change of condition in a patient, that they would be expected to notify the nurse and then to notify herself so that she could follow up appropriately. The DOR stated that she was familiar with Resident #8, and normally the resident was alert and oriented, and had none of the physical signs or symptoms that he was experiencing on February 12, 2025. She stated that the two therapists, Staff #8 and Staff #10, noted that Resident #8's status was off and notified the nurse, and then the provider, and then they notified her. The DOR stated that she went to the resident's room and assessed the resident. The DOR stated that she observed the resident had reduced orientation, was looking around the room, not aware of what was going on, and had dyskinetic, clonus, jerky movements. She confirmed there was a change of condition, and she stated she was concerned the resident was having a medical emergency. She then went to the nurse and the provider (Staff #55), and that after they talked to me, it seemed like they were more motivated to get things going. She stated that when she reported this to the provider, the provider was charting at the desk, and did not go assess the resident right away. She stated that she observed the provider and the Assistant Director of Nursing (ADON / Staff #73) both go into the resident's room to assess the resident 5-10 minutes later, and that they called EMS after that. The interview continued and the DOR stated that regarding the PTA (Staff #10), that her employment was ended due to a compliance issue, and more specifically that she had written a note insinuating nursing negligence. The DOR stated that the note was Staff #10's daily note from February 12, 2025, for Resident #8's treatment session. The note was then reviewed together. The DOR stated that she did not believe anything in Staff #10's note was fabricated or false. She confirmed that she believed the note was an accurate representation of events. Further, she stated that the nurse stated that Resident #8 was faking his symptoms. She stated that the note was first discovered by the facility's nurses during a chart review, and was escalated to the administrator (Staff #80). She stated that the administrator had contacted her via text message that Staff #10's note was detrimental to the facility and the provider. The DOR stated that she was not familiar with the facility's policy on neglect, but that she was aware that allegations of abuse, neglect, and fraud need to be reported to mandatory reporting sources. The DOR stated that Staff #10 did report her concerns of the nurse and provider neglecting a potential medical emergency to her right away. The DOR stated that she was not aware of the facility's neglect reporting policy that reporters are to be protected from retaliation. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephonic interview was conducted on March 14, 2025, at 1:20 PM, with a Physical Therapy Assistant (PTA /Staff #10). The PTA stated that on February 12, 2025, between 7:30 AM and 9:00 AM, she entered Resident #8's room for a therapy treatment along with the COTA (Staff #8). The PTA stated that the resident was not responding correctly, so the PTA directed that they would not get the resident out of bed due to safety concerns. The PTA stated that she reported the resident's change of condition to the floor nurse (Staff # 79), who stated that she had not worked that hall before and did not know the resident's normal baseline status. The PTA re-stated to the nurse that she was familiar with the resident's baseline status and that the resident was having a change of condition. The PTA stated that the nurse (Staff #79) was going to notify the charge nurse (Staff #30). She stated that the COTA (Staff #8) went to go notify the provider. The PTA stated at that point, she then went to the DOR and reported her concerns with the situation. The DOR then assessed the patient and went to the provider who said he would be down to assess the resident in 5-10 minutes. The PTA stated that then, herself and the DOR together went to the charge nurse (Staff #30), and the charge nurse said to both of us that Resident #8 was probably faking his symptoms. She stated that the facility was not going to send the resident to the emergency room at that point. She stated that approximately 20 minutes later, she observed the floor nurse (Staff #79) talking to the resident's sister. The PTA then requested to the resident's sister to talk in a private space, so they went to the therapy gym. The PTA stated that she was concerned that Resident #8 was having a medical emergency, and encouraged the resident's sister to request the resident to be sent out to the emergency room . She stated that she continued to treat her scheduled patients that morning, and that the DOR had told her that she talked to the provider again and emphasized to the provider that something was wrong with the resident, and the resident was sent to the hospital. She stated that at that time, she brought up her concerns of the nurse's and provider's negligence to the DOR, and then documented everything as it happened in her therapy note. The interview continued and the PTA stated that about a week and a half to two weeks after the incident on February 12, the facility discovered her therapy note from that date. She stated that the regional manager of the contracted therapy company contacted her and asked her to change her documentation in her therapy note from February 12. She stated that she was told her documentation sounded like it was targeting the facility. She stated that the regional manager explicitly told her she did nothing wrong in the incident, but just asked her to change her note. The PTA stated that the manager sent her a copy of her note with highlighted areas of what needed to be changed. The PTA provided a copy of the highlighted note when requested on March 4, 2025. The PTA stated she was worried about losing her job, so she did change the note. Additionally, she stated that she was terminated, and she never received or signed anything regarding disciplinary actions or termination. She stated that her contracted therapy company told her over the phone that the reason she was terminated was because her documentation was non-compliant and that she brought morale down. A telephonic interview was conducted with a Nurse Practitioner (NP / Staff #55), on March 4, 2025, at 1:44 PM. The NP stated that he was notified of Resident #8's change of condition on the morning of February 12, 2025. He stated that he was at the nurse's station. He stated he did not recall if he was notified at all prior to that. He additionally stated that he could not recall which staff informed him, or the time. He stated that he went down to the resident's room and saw the resident, but could not specify when. He stated that the resident was sent to the hospital, and was diagnosed with seizures, and readmitted to the facility on seizure medication. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the administrator (Staff #80) on March 4, 2025 at 1:51 PM. The video camera footage for the facility was requested for review for the date of February 12, 2025. The administrator stated that camera footage was not available, as the footage deletes after 72 hours. An interview was conducted with a Licensed Practical Nurse and charge nurse (LPN / Staff #30) on March 4, 2025, at 2:00 PM. The LPN stated that if she was informed of a medical change in a patient, that she would do an assessment, take vital signs, and notify the physician and family. Regarding Resident #8 on February 12, 2025, the LPN stated that she then went with the resident's sister and the social services director to the resident's room. She stated the resident was presenting as awkward, that he was dropping things, reaching for things, and there was a noted difference. She stated that I thought maybe he wasn't doing well, but maybe trying to look worse than it was. At that point, the LPN stated that she left the room and moved on. She believed it was around 10:00 AM that the provider went in to assess the resident. An interview was conducted with a Registered Nurse and ADON (Staff #73) on March 4, 2025, at approximately 2:30 PM. In regard to Resident #8 and the incident on February 12, 2025, the ADON stated that both the nurse and the therapist alerted her that Resident #8 was having a change of condition. The ADON then went to the provider (Staff #55) and requested that the provider assess the resident with her. The ADON and the provider went to the resident's room together and noted that the resident had altered mental status, not answering questions or responding to any directions, and staring off into nothing. The ADON stated that the provider instructed to send the resident to the emergency room . The ADON could not recall what time this occurred, but estimated that it was mid-morning. She stated that the emergency medical services (EMS) arrived at 11:09 AM and that the resident left the facility with EMS at 11:15 AM. The ADON stated that her understanding of neglect is a failure to provide necessary treatment and care for a resident, and that it could be a case of neglect if a resident is requiring emergency services and not receiving that service urgently. The ADON stated that the facility's policy is to report cases of neglect and abuse immediately, and to protect both residents and reporters from retaliation. A telephonic interview was conducted with Resident #8's sister on March 4, 2025, at 3:09 PM. She stated that on February 12, she arrived to the facility between 10:00 and 10:30 AM. She observed Resident #8 in his room, and saw that he was completely out of it, grabbing at people and the sidebars of his bed, and rolling over on his side. She stated the resident was not aware that she was there. She stated that the PTA (Staff #10) asked her to talk and they went to speak privately in the therapy gym, and the PTA suggested that she make sure he gets the help he needed. She stated that one of the nurses told her that Resident #8 was going to be sent out to the hospital on non-emergent transport, and at that point, she stated that she went to the nurse's station and told facility staff I want you to call emergency (services) now. She stated that during that morning, she overheard a staff member state that sometimes Resident #8 makes stuff up, insinuating that he was faking his symptoms. She stated that as an outcome, that Resident #8 went to the hospital and was transferred to the intensive care unit (ICU), and was diagnosed with sepsis from a urinary tract infection. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephonic interview was conducted with a Registered Nurse (RN / Staff #79) on March 4, 2025, at 3:35 PM. She stated that she was Resident #8's floor nurse on February 12, 2025. She stated that a therapist notified her of the resident's change and asked if the resident had been like that all morning, but could not recall what time this occurred. She stated that the provider (Staff #55) arrived to the building between 9:00 and 10:00 AM. She stated that she followed the provider to the resident's room when he went to assess the resident. She stated that it looked like the resident was having absence seizures because the resident was drifting off. She stated that the provider instructed her to send the resident to the hospital, but he instructed her to wait until he filled out his note. She stated that she overhead and gathered from the charge nurse (Staff #30) that Resident #8 does this all the time, that those were not her exact words, but that she insinuated that she meant the resident was having behaviors instead of having real symptoms. Finally, Staff #79 re-stated that she was instructed by the provider to send the resident to the emergency room after they had assessed the resident in his room, but to wait until the provider finished his physician note first. A telephonic interview was conducted on March 4, 2025, at 3:48 PM, with the Regional Manager for the facility's contracted therapy company (Staff #112). She stated she was familiar with the PTA (Staff #10), and that she was terminated February 27, 2025 for documenting things in conversations between herself and nursing staff. She stated that no, she did not believe Staff #10 was falsely documenting the events in her note. She stated that in Staff #10's treatment note, there was documentation of a conversation with nursing. She stated that on February 20, 2025, she had a training with Staff #10, educating her on correcting her documentation, and from the date of the training moving forward, there were no further incidents where Staff #10 demonstrated any HR issues or actions that needed correction. Additionally, there were no further incidents or trainings of any kind. The Regional Manager stated that it was a unanimous decision between the managers of the contract therapy company and the facility's administrator that Staff #10 would be terminated. An interview was conducted with the Director of Nursing (DON / Staff #95) on March 4, 2025, at 4:27 PM, who stated that if a resident who is normally alert and oriented is found to be lethargic, that he would expect the nurse to notify the provider, then follow the provider's orders and to document it in a progress note. The DON stated that his understanding of neglect would be withholding care from a resident that causes harm. The DON stated that if a resident had a delay in care that was provided, that in order to meet the criteria of neglect, that you would have to prove that harm was done. The interview continued and the DON stated in regard to Resident #8, that he could not recall which staff asked him to go assess the resident. The DON stated that he was in his morning meeting until around 10:00 AM, and after that, at approximately 10:30, he went to assess Resident #8 in his room. He stated he talked to the floor nurse (Staff #79) who was unfamiliar with the resident and did not know what the resident's baseline was. The DON stated that he met with the provider and told the provider that the resident had definitely changed, and that he talked to the floor nurse (Staff #79) and instructed her that we need to send (Resident #8) out to the hospital, then the nurse called 911. He stated that the resident was transferred to a hospital for a higher level of care. He stated that the resident was diagnosed with a urinary tract infection and Influenza A. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 4, 2025, at 5:26 PM, an interview was conducted with the administrator (Staff #80). The administrator stated that if a resident were to demonstrate signs and symptoms of a possible medical emergency, that his expectation would be for staff to send the resident to the hospital or to get a second set of eyes to assess the resident. The administrator stated that neglect is intentionally or unintentionally preventing care of a resident, and that it could lead to loss of life or a worsening of an existing medical condition. The administrator stated he was aware of allegations of neglect of Resident #8 when the resident's sister reached out to the ADON and the DON via email. Additionally, Staff #80 stated that a few weeks after February 12, 2025, the therapy note from Staff #10 was brought to his attention, and that the therapist never reported concerns of neglect to anyone on the date of February 12, 2025. He stated that the therapy note alleged that the provider would assess the resident in 10-15 minutes and that a nursing staff made a comment that the resident was faking his symptoms. He stated that Staff #10 was terminated and that he did not know why, and that he never observed any negative behaviors from Staff #10. He stated that the facility has a mandatory reporting policy on allegations of neglect, and that Staff #10 did not report her concerns timely, and that the allegation of neglect was not investigated or reported to the mandatory reporting sources. Additionally, the administrator stated that anybody should feel comfortable reporting allegations of neglect, and that there is protection from retaliation for reporters. Review of the facility policy titled Resident Rights/Dignity: Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated January 1, 2024, revealed all reports of resident neglect are reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If resident neglect is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Immediately is defined as within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. All allegations are thoroughly investigated. The administrator initiates investigations. The administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated with the facility. Review of the facility policy titled Assessments/Care Planning: Change in a Resident's Condition or Status, dated January 1, 2024, revealed the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Review of the facility policy titled Assessments/Care Planning: Resident Examination and Assessment, dated January 1, 2024, revealed to notify the physician of any abnormalities such as, but not limited to: abnormal vital signs, labored breathing, or change in cognitive, behavioral or neurological status from baseline. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Documentation: Charting and Documenting, dated January 1, 2024, revealed all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record may be electronic, manual or a combination. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Documentation of procedures and treatments will include care-specific details, including: the assessment data and/or any unusual findings obtained during the procedure/treatment; how the resident tolerated the procedure/treatment; and notification of family, physician or other staff, if indicated.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on interviews, review of facility documentation, and review of policy and procedures, the facility failed to assess a resident for a change of condition timely, and provide timely transfer to emergency services for one resident (#8). Additionally, the facility failed to obtain a physician order for administration of oxygen therapy according to professional standards for one resident (#8). The deficient practice could result in a delay of care for a resident, leading to a worsening medical condition, and could lead to a physician not being aware of a resident's respiratory status regarding oxygen use. Findings Include: -Regarding resident assessment and timely transfer to emergency services for Resident #8: Resident #8 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease, post-polio syndrome, chronic pain syndrome, asthma, and dyspnea. An admission minimum data set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview or Mental Status (BIMS) score of 15, indicating intact cognition. Additionally, Section E revealed that the resident had no potential indicators of psychosis, and no physical behavioral symptoms. There was no evidence of physician orders for 72-hour monitoring of a change of condition for Resident #8. A physician order dated February 12, 2025, at 10:58 AM, indicated to send Resident #8 to the emergency room (ER) for further evaluation of seizure like symptoms. An Alert Charting note dated February 12, 2025, at 11:09 AM, indicated that Resident #8 appears to be altered from baseline mentation with possible seizure activity. Physician notified and resident sent to the ER for evaluation. Emergency Medical Services (EMS) arrived at 11:09 AM, and the resident left the facility via ambulance at 11:15 AM. A therapy daily treatment note dated February 12, 2025, by a Certified Occupational Therapy Assistant (COTA /Staff #8), revealed that a co-treatment session for Resident #8 was completed with physical therapy. The note stated that Resident #8 was not very responsive that day, the COTA informed nursing and the provider, and communicated with the resident's sister who stated she has never seen her brother like that. The note further stated the resident was sent out to the emergency department via ambulance. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A therapy daily treatment note dated February 12, 2025, by a Physical Therapy Assistant (PTA / Staff #10), revealed a co-treatment of Resident #8 with a COTA to ensure patient safety due to a medical change. The note revealed the PTA indicated that the nurse needs to check on the resident due to a mental status change. The resident demonstrated increased confusion, difficulty with communication, oriented only to self, as well as dyskinetic movements followed by stilled body movements, blank expression, and lack of eye tracking. Nursing staff indicated that the resident is on medication for a urinary tract infection. The COTA informed the provider, and the provider indicated I will check on him in 5-10 minutes when I get down there. The PTA and COTA addressed other nursing staff and other nursing staff indicated the patient is faking, and is fine. The PTA discussed with the DOR who continued to ask the facility staff to check and follow up on the resident. The PTA discussed the resident's status with the resident's family about what occurred during attempted therapy session. The resident was sent to the emergency department. An email dated February 14, 2025, from Resident #8's sister sent to the Director of Nursing (DON / Staff #95) and to the Assistant Director of Nursing (ADON / Staff #73), revealed that Resident #8 is now in the intensive care unit due to a severe infection from a urinary tract infection, and that she had communicated her concerns in previous emails on February 5 and 11, with no response from the facility staff. Additionally, the email revealed the resident's sister's concern that when she arrived to the facility on the morning of February 12, that there was a delay in the provider assessing the resident, and additionally the provider took more time to write at his desk before the resident was sent to the emergency room . The email revealed that then the resident's sister instructed the nurse to call 911 and not wait for the doctor's note, at which point the nurse then called 911. Additionally, the email revealed the resident's sister's allegation that the facility staff ignored (her) requests and alerts to (Resident #8's) condition that led to the resident being in the intensive care unit. Records from the discharging hospital revealed a physician note dated February 15, 2025, that Resident #8 was transferred to the hospital from another hospital for a higher level of care. Resident #8 was at a skilled nursing facility, had a urine culture that grew Enterobacter, and subsequently developed urosepsis and was sent to the emergency room . Resident #8 was found to be obtunded and hypotensive and transferred to the intensive care unit (ICU) for norepinephrine and fluid resuscitation, and was treated for acute kidney injury, possible seizure, and acute respiratory failure secondary to influenza A. An interview was conducted on March 4, 2025, at 9:54 AM with a Certified Occupational Therapy Assistant (COTA / Staff #8). The COTA stated that if therapists were to notice a possible change in condition of a resident during a treatment session they would alert the nurse, check the resident's vitals, and possibly communicate with the provider. The COTA stated that the facility expects therapists to document the change of condition, to chart exactly what is going on and that nursing was informed, and to notify the Director of Rehab (DOR). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The interview continued and the COTA stated in regard to Resident #8, that she noticed a big change in him on February 12, 2025. She stated prior to February 12, the resident was a little confused the whole time he was here, and that he had weird hand gestures. Normally, Resident #8 could converse with the therapists and follow directions. However, on the day of February 12, the COTA stated that she entered the resident's room around 9:00 AM. The resident was in bed, disoriented, and very different from any other day: he was unable to verbalize anything, could not follow any kind of direction, flailing his arms, randomly reaching places, and not oriented to himself, the time, or the place. Additionally, the COTA stated that during this therapy session on February 12, she was attempting to perform a co-treatment with a Physical Therapy Assistant (PTA / Staff #10), and that they both let the charge nurse (Staff #30) know about the resident's changes right away. The COTA stated that the nurse did not come to the resident's room to assess the resident, and the nurse responded by stating that this was typical behavior from Resident #8. The COTA stated she then re-iterated to the nurse that this was not typical behavior from the resident, and the nurse replied that this is typical behavior from the resident at night. She stated she did not proceed to assist Resident #8 out of bed because she was concerned about his status. The COTA stated that at that time, she also informed the DOR (Staff #20) what was going on with Resident #8, and that no staff came to assess the resident during the 10-15 minutes that she was in the room with the resident. The COTA stated that Resident #8's sister came in the middle of the attempted therapy session, and that the resident's sister stated that she was also very concerned with the resident's status and had tried to tell the facility staff of the change the prior evening on February 11. The COTA stated that she had to start treatments with her other scheduled patients but that she continued to go back to the room and check on Resident #8 several times, and that it was approximately 1 to 1.5 hours before EMS came to the facility for the resident. An interview was conducted on March 4, 2025, at 10:17 AM, with a rehab tech (Staff #18). Staff #18 stated that he had observed Resident #8 on previous dates and that normally the resident was able to converse, and was oriented to himself, the place, and aware of his surroundings. Staff #18 stated that on February 12, he passed by the resident's room and observed the resident looked confused while working with the therapist. Additionally, Staff #18 stated that he witnessed a conversation between the PTA (Staff #10) and the nurse (Staff #30) where the PTA was expressing her concern about the resident to the nurse. Staff #18 stated that he passed by and did not hear the nurse's response. He additionally stated that in regard to Staff #10, I think she was let go, but could not specify why. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with an Occupational Therapist and Director of Rehab (DOR / Staff #20) on March 4, 2025, at 11:33 AM. The DOR stated that if therapists were to notice a change of condition in a patient, that they would be expected to notify the nurse and then to notify herself so that she could follow up appropriately. The DOR stated that she was familiar with Resident #8, and normally the resident was alert and oriented, and had none of the physical signs or symptoms that he was experiencing on February 12, 2025. She stated that the two therapists, Staff #8 and Staff #10, noted that Resident #8's status was off and notified the nurse, and then the provider, and then they notified her. The DOR stated that she went to the resident's room and assessed the resident. The DOR stated that she observed the resident had reduced orientation, was looking around the room, not aware of what was going on, and had dyskinetic, clonus, jerky movements. She confirmed there was a change of condition, and she stated she was concerned the resident was having a medical emergency. She then went to the nurse and the provider (Staff #55), and that after they talked to me, it seemed like they were more motivated to get things going. She stated that when she reported this to the provider, the provider was charting at the desk, and did not go assess the resident right away. She stated that she observed the provider and the Assistant Director of Nursing (ADON / Staff #73) both go into the resident's room to assess the resident 5-10 minutes later, and that they called EMS after that. A telephonic interview was conducted on March 4, 2025, at 12:38 PM, with a CNA (Staff #2), who stated that she worked with Resident #8 on the date of February 12, 2025. The CNA stated that she arrived at 6:00 AM, and when she first rounded, the resident was sleeping through the morning. Sometime between 8:00 and 10:00 AM, she noticed the resident was confused and not himself, and was not confused before that date, and that the resident's sister was in the room at that time. The CNA stated that Resident #8 was not making sense when he talked, and that he could not use his urinal like he could before. The CNA told the nurse, but unable to specify who the nurse was. She stated the nurse came and assessed the resident and talked with the resident's sister. She stated some time after that, the resident discharged to the hospital, but could not specify when. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephonic interview was conducted on March 14, 2025, at 1:20 PM, with a Physical Therapy Assistant (PTA /Staff #10). The PTA stated that on February 12, 2025, between 7:30 AM and 9:00 AM, she entered Resident #8's room for a therapy treatment along with the COTA (Staff #8). The PTA stated that the resident was not responding correctly, so the PTA directed that they would not get the resident out of bed due to safety concerns. The PTA stated that she reported the resident's change of condition to the floor nurse (Staff # 79), who stated that she had not worked that hall before and did not know the resident's normal baseline status. The PTA re-stated to the nurse that she was familiar with the resident's baseline status and that the resident was having a change of condition. The PTA stated that the nurse (Staff #79) was going to notify the charge nurse (Staff #30). She stated that the COTA (Staff #8) went to go notify the provider. The PTA stated at that point, she then went to the DOR and reported her concerns with the situation. The DOR then assessed the patient and went to the provider who said he would be down to assess the resident in 5-10 minutes. The PTA stated that then, herself and the DOR together went to the charge nurse (Staff #30), and the charge nurse said to both of us that Resident #8 was probably faking his symptoms. She stated that the facility was not going to send the resident to the emergency room at that point. She stated that approximately 20 minutes later, she observed the floor nurse (Staff #79) talking to the resident's sister. The PTA then requested to the resident's sister to talk in a private space, so they went to the therapy gym. The PTA stated that she was concerned that Resident #8 was having a medical emergency, and encouraged the resident's sister to request the resident to be sent out to the emergency room . She stated that she continued to treat her scheduled patients that morning, and that the DOR had told her that she talked to the provider again and emphasized to the provider that something was wrong with the resident, and the resident was sent to the hospital. A telephonic interview was conducted with a Nurse Practitioner (NP / Staff #55), on March 4, 2025, at 1:44 PM. The NP stated that he was notified of Resident #8's change of condition on the morning of February 12, 2025. He stated that he was at the nurse's station. He stated he did not recall if he was notified at all prior to that. He additionally stated that he could not recall which staff informed him, or the time. He stated that he went down to the resident's room and saw the resident, but could not specify when. He stated that the resident was sent to the hospital, and was diagnosed with seizures, and readmitted to the facility on seizure medication. An interview was conducted with the administrator (Staff #80) on March 4, 2025 at 1:51 PM. The video camera footage for the facility was requested for review for the date of February 12, 2025. The administrator stated that camera footage was not available, as the footage deletes after 72 hours. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with a Licensed Practical Nurse and charge nurse (LPN / Staff #30) on March 4, 2025, at 2:00 PM. The LPN stated that if she was informed of a medical change in a patient, that she would do an assessment, take vital signs, and notify the physician and family. Regarding Resident #8 on February 12, 2025, the LPN stated that she was first notified of the resident's change of condition by the floor nurse (Staff #79), sometime between 7:00 and 9:00 AM. She stated that she went to the resident's room and spoke to the resident asking if he was ok, and the resident stated that he needed a pain pill. She stated that she did not assess the resident's vital signs, that a CNA took the resident's vitals, and she did not remember what the vitals were. The LPN stated that she left the room and notified the floor nurse of the resident's request for a pain pill. The LPN stated that the resident seemed normal to her. She stated that approximately 1-2 hours later, the resident's sister arrived and noticed the resident was different, and the resident's sister got the social services director. The LPN stated that she then went with the resident's sister and the social services director to the resident's room. She stated the resident was presenting as awkward, that he was dropping things, reaching for things, and there was a noted difference. She stated that I thought maybe he wasn't doing well, but maybe trying to look worse than it was. At that point, the LPN stated that she left the room and moved on. She believed it was around 10:00 AM that the provider went in to assess the resident. An interview was conducted with a Registered Nurse and ADON (Staff #73) on March 4, 2025, at approximately 2:30 PM. The ADON stated that if a change of condition was noted in a resident, that she would expect the change of condition would be communicated up the chain of command from a nurse to a charge nurse to a provider, and to send the resident to a higher level of care if needed. She stated that there is a change of condition process that the facility follows which includes following a change of condition sheet and starting the resident on 72-hour monitoring. In regard to Resident #8 and the incident on February 12, 2025, the ADON stated that both the nurse and the therapist alerted her that Resident #8 was having a change of condition. The ADON stated that she was not aware of what Resident #8's baseline status was. The ADON then went to the provider (Staff #55) and requested that the provider assess the resident with her. The ADON and the provider went to the resident's room together and noted that the resident had altered mental status, not answering questions or responding to any directions, and staring off into nothing. The ADON stated that the provider instructed to send the resident to the emergency room . The ADON could not recall what time this occurred, but estimated that it was mid-morning. She stated that EMS arrived at 11:09 AM and that the resident left the facility with EMS at 11:15 AM. The ADON stated that if a resident has a change of condition that is not addressed timely, then the resident's condition could worsen. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephonic interview was conducted with Resident #8's sister on March 4, 2025, at 3:09 PM. The resident's sister stated that she noticed a change in the resident during the late afternoon to early evening of February 11, 2025, and she had brought her concerns to facility staff that afternoon on February 11. She stated that on February 12, she arrived to the facility between 10:00 and 10:30 AM. She observed Resident #8 in his room, and saw that he was completely out of it, grabbing at people and the sidebars of his bed, and rolling over on his side. She stated the resident was not aware that she was there. She stated that the PTA (Staff #10) asked her to talk and they went to speak privately in the therapy gym, and the PTA suggested that she make sure he gets the help he needed. She stated that one of the nurses told her that Resident #8 was going to be sent out to the hospital on non-emergent transport, and at that point, she stated that she went to the nurse's station and told facility staff I want you to call emergency (services) now. She stated that during that morning, she overheard a staff member state that sometimes Resident #8 makes stuff up, insinuating that he was faking his symptoms. She stated that as an outcome, that Resident #8 went to the hospital and was transferred to the intensive care unit (ICU), and was diagnosed with sepsis from a urinary tract infection. A telephonic interview was conducted with a Registered Nurse (RN / Staff #79) on March 4, 2025, at 3:35 PM. The RN stated that if a resident is having a possible change of condition, that she would ask other staff to see if the resident is different from baseline, then follow-up with the doctor, and chart the symptoms and instructions from the provider in a progress note. She stated that she was Resident #8's floor nurse on February 12, 2025. She stated that she arrived to the facility around 5:45 AM, and first saw the resident in his room between 7:45 to 8:00 AM to administer his medication. She stated that he was not very awake, the resident grunted, and could not arouse to take medications, and the nurse left the room. She came back to the resident at 8:30 AM. She stated she tried to administer his medication, however he could not take his medications. She stated that then she crushed the medications and the resident was able to take the medications. She stated that she then asked other staff what the resident's baseline was, and that staff stated that this was not normal for Resident #8. She stated that a therapist notified her of the resident's change and asked if the resident had been like that all morning, but could not recall what time this occurred. She stated that the provider (Staff #55) arrived to the building between 9:00 and 10:00 AM. She stated that she followed the provider to the resident's room when he went to assess the resident. She stated that it looked like the resident was having absence seizures because the resident was drifting off. She stated that the provider instructed her to send the resident to the hospital, but he instructed her to wait until he filled out his note. She stated that she overhead and gathered from the charge nurse (Staff #30) that Resident #8 does this all the time, that those were not her exact words, but that she insinuated the resident was having behaviors instead of having real symptoms. She also stated she heard the resident's sister state that she had alerted the facility staff the day before of her concerns that her brother was off. Finally, Staff #79 re-stated that she was instructed by the provider to send the resident to the emergency room after they had assessed the resident in his room, but to wait until the provider finished his physician note first. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with a Case Manager (Staff #81) on March 4, 2025, at 4:15 PM. She stated that on February 11, 2025, Resident #8's sister came to her and stated that there was something going on with Resident #8 and asked Staff #81 to check on him. Staff #81 stated she was familiar with the resident and had regular visits with him prior to this date. She stated normally, the resident was very alert. She went to the resident's room on February 11, and stated that I had never seen him like that. She stated his eyes were bulging, he was slumped over, was grabbing at his inhalers, and was not responding when spoken to. Then, Staff #81 stated that she went to the charge nurse (Staff #30) and brought up her concerns, to which the charge nurse replied he's fine. She stated she did not see anybody come to the room to assess the resident while she was there or directly afterward. She stated approximately 15 minutes later, she was told by nursing staff that Resident #8 was a little lethargic. An interview was conducted with the Director of Nursing (DON / Staff #95) on March 4, 2025, at 4:27 PM, who stated that if a resident who is normally alert and oriented is found to be lethargic, that he would expect the nurse to notify the provider, then follow the provider's orders and to document it in a progress note. The DON stated that if a resident had a delay in care that was provided, that in order to meet the criteria of neglect, that you would have to prove that harm was done. The DON stated in regard to Resident #8, that he could not recall which staff asked him to go assess the resident. The DON stated that he was in his morning meeting until around 10:00 AM, and after that, at approximately 10:30, he went to assess Resident #8 in his room. He stated he talked to the floor nurse (Staff #79) who was unfamiliar with the resident and did not know what the resident's baseline was. The DON stated that he met with the provider and told the provider that the resident had definitely changed, and that he talked to the floor nurse (Staff #79) and instructed her that we need to send (Resident #8) out to the hospital, then the nurse called 911. He stated that the resident was transferred to a hospital for a higher level of care. He stated that the resident was diagnosed with a urinary tract infection and Influenza A. On March 4, 2025, at 5:26 PM, an interview was conducted with the administrator (Staff #80). The administrator stated that if a resident were to demonstrate signs and symptoms of a possible medical emergency, that his expectation would be for staff to send the resident to the hospital or to get a second set of eyes to assess the resident. The administrator declined to state the impact on a resident if staff failed to assess and respond to a resident's change of condition timely, and stated I stay out of the clinical side of things. -Regarding physician orders for oxygen therapy for Resident #8: Review of the O2 Sats Summary log revealed the resident was on room air on all log entries except the following entries where the resident was documented to receive oxygen therapy via nasal cannula: -2/2/2025: 93.0% Oxygen via Nasal Cannula -2/3/2025: 97.0% Oxygen via Nasal Cannula -2/4/2025: 93.0% Oxygen via Nasal Cannula -2/5/2025: 97.0% Oxygen via Nasal Cannula -2/5/2025: 91.0% Oxygen via Nasal Cannula (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2/6/2025: 76.0% Oxygen via Nasal Cannula -2/7/2025: 93.0% Oxygen via Nasal Cannula -2/7/2025: 99.0% Oxygen via Nasal Cannula -2/11/2025: 92.0% Oxygen via Nasal Cannula There was no evidence of a physician order for oxygen use for the timeframe of the resident's admission on January 28, 2025 until discharge to the hospital on February 12, 2025. Review of the care plan revealed no evidence of a care plan for oxygen use for the timeframe of the resident's admission on January 28, 2025 until discharge to the hospital on February 12, 2025. An interview was conducted with a Registered Nurse and ADON (Staff #73) on March 4, 2025, at approximately 2:30 PM. The ADON stated if a resident were to need oxygen, that nurses contact the provider to let them know what is going on and then document that in a progress note, and that oxygen use should be incorporated into the resident's care plan. The ADON stated that the provider should be aware and directing treatment involving oxygen therapy. The medical record was reviewed and the ADON stated there were no oxygen orders for the timeframe of the resident's original admission, and the ADON stated I think the orders just needed to be put in. An interview was conducted on March 4, 2025, at 4:27 PM with the DON (Staff #95), who stated that a nurse can initiate oxygen therapy if needed, then notify the provider, then place a physician order for oxygen use. The DON stated that the importance of having a physician order for oxygen is that it allows for continuity of care, and that it triggers the nurses to complete a specific assessment, and that it helps the facility to care plan appropriately for the resident. The clinical record was reviewed together for Resident #8 and the DON stated that there were no physician orders for oxygen use for Resident #8 during his original admission to the facility from January 28, 2025 through February 12, 2025. The DON confirmed on the O2 Sats Summary log that the resident had been receiving oxygen therapy. The DON stated that this would not meet his expectation, that he would expect for the resident to have physician orders for oxygen use. Additionally, the DON stated that the impact on a resident could be administration of too much oxygen which could lead to altered mental status in a resident. Review of the facility policy titled Assessments/Care Planning: Change in a Resident's Condition or Status, dated January 1, 2024, revealed the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Review of the facility policy titled Assessments/Care Planning: Resident Examination and Assessment, dated January 1, 2024, revealed to notify the physician of any abnormalities such as, but not limited to: abnormal vital signs, labored breathing, or change in cognitive, behavioral or neurological status from baseline. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Documentation: Charting and Documenting, dated January 1, 2024, revealed all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record may be electronic, manual or a combination. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Documentation of procedures and treatments will include care-specific details, including: the assessment data and/or any unusual findings obtained during the procedure/treatment; how the resident tolerated the procedure/treatment; and notification of family, physician or other staff, if indicated. Review of the facility policy titled Respiratory/Pulmonary Conditions: Oxygen Administration, dated January 1, 2024, revealed the purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035277	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Lakeside	3401 North Lockwood Drive Lakeside, AZ 85929

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on interviews, review of facility documentation, and review of policy and procedures, the facility failed to maintain a complete and accurate medical record for one resident (#8) regarding administration of oxygen therapy dose. The deficient practice could result in an incomplete medical record which could lead to interdisciplinary team members not being aware of a resident's respiratory status regarding oxygen use. Findings Include: Resident #8 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease, post-polio syndrome, chronic pain syndrome, asthma, and dyspnea. An admission minimum data set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview or Mental Status (BIMS) score of 15, indicating intact cognition. Section O indicated that the resident was not receiving oxygen therapy on admission or while a resident. Review of the O2 Sats Summary log revealed the resident was on room air on all log entries except the following entries where the resident was documented to receive oxygen therapy via nasal cannula: -2/2/2025: 93.0% Oxygen via Nasal Cannula -2/3/2025: 97.0% Oxygen via Nasal Cannula -2/4/2025: 93.0% Oxygen via Nasal Cannula -2/5/2025: 97.0% Oxygen via Nasal Cannula -2/5/2025: 91.0% Oxygen via Nasal Cannula -2/6/2025: 76.0% Oxygen via Nasal Cannula -2/7/2025: 93.0% Oxygen via Nasal Cannula -2/7/2025: 99.0% Oxygen via Nasal Cannula -2/11/2025: 92.0% Oxygen via Nasal Cannula There was no evidence of documentation of the dose of oxygen that was administered to the resident during this timeframe. There was no evidence of a provider order for oxygen use for the timeframe of the resident's admission on January 28, 2025 until discharge to the hospital on February 12, 2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan revealed no care plan for oxygen use for the timeframe of the resident's admission on January 28, 2025 until discharge to the hospital on February 12, 2025. An interview was conducted with a Registered Nurse and ADON (Staff #73) on March 4, 2025, at approximately 2:30 PM. The ADON stated if a resident were to need oxygen, that nurses contact the provider to let them know what is going on and then document that in a progress note, and that oxygen use should be incorporated into the resident's care plan. The medical record was reviewed and the ADON stated there were no oxygen orders for the timeframe of the resident's original admission, and the ADON stated I think the orders just needed to be put in. Additionally, the ADON stated that that she could not find in the clinical record the dose of oxygen that the resident was receiving during this timeframe. An interview was conducted on March 4, 2025, at 4:27 PM with the DON (Staff #95), who stated that a nurse can initiate oxygen therapy if needed, then notify the provider, then place a physician order for oxygen use. The DON stated that the importance of having a physician order for oxygen is that it allows for continuity of care, and that it triggers the nurses to complete a specific assessment, and that it helps the facility to care plan appropriately for the resident. The clinical record was reviewed together for Resident #8 and the DON stated that there were no physician orders for oxygen use for Resident #8 during his original admission to the facility from January 28, 2025 through February 12, 2025. The DON confirmed on the O2 Sats Summary log that the resident had been receiving oxygen therapy. Additionally, the DON stated that normally, the dose of oxygen is recorded and monitored in the treatment administration record, however if there is no physician order, then it will not be triggered to be monitored on the record. The DON stated that this would not meet his expectation, that he would expect for the resident to have physician orders for oxygen use. Additionally, the DON stated that the impact on a resident could be administration of too much oxygen which could lead to altered mental status in a resident. Review of the facility policy titled Documentation: Charting and Documenting, dated January 1, 2024, revealed all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record may be electronic, manual or a combination. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Documentation of procedures and treatments will include care-specific details, including: the assessment data and/or any unusual findings obtained during the procedure/treatment; how the resident tolerated the procedure/treatment; and notification of family, physician or other staff, if indicated. Review of the facility policy titled Respiratory/Pulmonary Conditions: Oxygen Administration, dated January 1, 2024, revealed the purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure.