

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 07/09/2025
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure an alleged violation involving two residents (#37 and #42) was reported to the State Agency. Based on clinical record review, resident and staff interviews, review of the facility documentation and policy, the facility failed to ensure an alleged violation involving two residents (#37 and #42) was reported to the State Agency (SA). Findings include: Regarding Resident #37 Resident #37 was admitted on [DATE], with a diagnosis of anxiety disorder, chronic obstructive pulmonary disease, dependence on supplemental oxygen, dementia, and cognitive communication deficit. Review of the Minimum Data Set (MDS) assessment revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12/15, indicating the resident had moderate cognitive impairment. The care plan, focusing on behavior, dated May 2, 2023, revealed the resident frequently misplaced items accusing others of taking them, and then needed help finding them. Review of a progress note dated June 27, 2025, indicated that during the night shift, the nurse found the resident and another resident, in the room lying on the floor. Resident #37 claimed that she was awoken by the other resident, and that he had a cord in his hand, fearing he would use the cord to choke her. However, later when Emergency Medical Services (EMS) arrived, the resident stated that she had been choked by the other resident with the cord and that this had happened the previous week as well. Regarding Resident #42 Resident #42 was admitted to the facility on [DATE], with a diagnosis of encephalopathy, cognitive communication deficit, dementia with behavioral disturbance, schizoaffective disorder, depression, and anxiety disorder. Review of the MDS dated [DATE], revealed the resident had a BIMS score of 6/15, indicating the resident had severe cognitive impairment. The care plan, focusing on impaired cognitive function, dated June 13, 2025, revealed the resident had impaired thought processes related to encephalopathy, cognitive communication deficit, and dementia. The resident was receiving anti-psychotic medication related to combativeness and schizoaffective disorder. The care plan, focusing on behavior, dated June 20, 2025, revealed the resident had physical behaviors and wandering. Review of a hospital visit record, dated June 20, 2025, stated patient has history of dementia and got angry and was violent with staff at haven of lakeside. PD (police department) brought patient here. Came from Lakeside after punching staff. Review of resident #42's progress note revealed no documentation of this incident. However, a progress note, dated June 27, 2025, revealed the resident was found on the floor, in another resident's room, yelling at staff and making incoherent statements. The nursing staff performed a focused assessment finding no injuries and the resident was redirected to his room. Resident was sent to the hospital for further treatment. On July 1, 2025, it was reported to the SA (State Agency) from APS (Adult Protective Services) that resident #37 claimed she was attacked by resident #42 with a cord. There is no evidence in the clinical record or in the facility documentation that this incident was reported to the SA. A phone interview was conducted on July 9, 2025, at 1:50 PM, with resident #37's POA (Power of Attorney). She stated I do not know anything more that happened regarding this incident except for what staff at the facility told me. A male resident went into her room while she was sleeping and attacked her. They did not say exactly what happened but that they were sending her to the ER (Emergency Room). She had a minor injury to her arm. Resident #37 told the hospital staff she was attacked by a male resident with a black cord. However, the hospital did not find any injuries based on this information. She stated, I know that she has problems, and that she does make things up. Further stating, she understands how they think something happened. The POA stated she did not know if anything happened or not. She stated the facility told her the other resident was not coming back to the facility. A phone interview was conducted on July 9, 2025, at 4:04 PM, with LPN (Licensed Practical Nurse, staff #100), who was involved in this incident. The nurse stated the CNA (Certified Nursing Assistant) came and told me she needed help because two residents were on the floor. Resident #42 was on the floor sitting up, half in the doorway and half in the hallway, and he had a black cord in his hand. Resident #37 was laying on the floor and had a skin tear on her elbow and faint mark of blood on her thigh. She stated that, after she assessed her, she determined the blood on the thigh was just blood from the skin tear on her elbow. She was saying that resident #42 came into her room and pulled her out of bed. She stated that the biggest concern was to get that cord out of resident #42's hands. She stated that she asked him what happened and took the cord away from him. She stated the CNA that was in the room with her was saying, he was trying to kill her, and he pulled her out of bed. She stated that she started shaking her head no, so she would stop talking and escalating the situation. She further stated she asked resident #42 why he was in the room, and</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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