STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035073	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven Health Green Valley, LLC	150 North LA Canada Drive Green Valley, AZ 85614

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that one resident (#47) had the right to privacy. The deficient practice could result in residents being denied their rights and impact psychosocial well-being. Findings include: Resident #47 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia with other behavioral disturbance, adjustment disorder, and major depressive disorder. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 6 indicating the resident had a severe cognitive impairment. Review of the care plan dated February 14, 2023 revealed a behavior care plan related to impaired cognition as evidenced by verbal aggression toward staff, rejecting needed care, yelling at staff, and obsessing over particular items. A progress note dated October 11, 2023 revealed that the resident gets easily irritated with other residents and staff, yells out and is often impulsive. A behavior health service provider is present in the facility and advised. A progress note dated October 16, 2023 revealed that a nurse was called into the unit due to a resident-to-resident confrontation. Residents were heard yelling at each other in their room and the certified nursing assistants (CNAs) went into the room where residents were found arguing and pulling on each other's clothes. The roommate (#47) was upset because resident #23 was rummaging through her closet. Resident #47 stated that resident #23 slapped her. The residents were separated and one was moved to another room to prevent any further altercations. Both residents were assessed by the nurse and no injuries or marks were noted, vital signs were stable, and no complaints of pain from either resident. A physician's note dated October 23, 2023 included that resident #47 recently had an altercation with another resident. Both residents were yelling at each other and arguing about clothes. Resident #47 reported that she was slapped by the other resident. The incident was unwitnessed and there were no signs of injuries reported by nursing staff. -Resident #23 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, hypertensive chronic kidney disease, anxiety disorder, and a major depressive disorder. (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 3 indicating the resident had a severe cognitive impairment. Review of the the care plan dated September 12, 2023 revealed a behavior care plan related to dementia as evidenced by impaired safety awareness, physical behaviors, resistive to care, verbal behaviors, and wandering/exit seeking. Interventions included to administer medications as ordered, anticipate and meet the resident's needs, and encourage as much participation/interaction as possible during care activities. A behavior progress note dated September 16, 2023 revealed that a resident was restless, wandering/pacing the halls, and exit seeking. The resident was also noted hoarding objects in pockets and was difficult to redirect. A behavior progress note dated September 28, 2023 revealed that the resident was noted wandering into another resident's room this afternoon. The other resident became agitated and insisted that the resident leave. Staff was able to redirect both residents. Staff reported that the resident continues hoarding everyday objects in her purse, closet, and dresser drawers including dirty pull-ups. A progress note dated October 7, 2023 revealed that resident #23 was transferred to another room due to not getting along with her roommate. A progress note dated October 16, 2023 revealed that a nurse was called into the unit due to a resident-to-resident confrontation. Residents were heard yelling at each other in their room and the certified nursing assistants (CNAs) went into the room where residents were found arguing and pulling on each other's clothes. The roommate (#47) was upset because resident #23 was rummaging through her closet. Resident #47 stated that resident #23 slapped her. The residents were separated and one was moved to another room to prevent any further altercations. Both residents were assessed by the nurse and no injuries or marks were noted, vital signs were stable, and no complaints of pain from either resident. A progress note dated October 18, 2023 at 11:47 a.m. revealed that resident #23 continues to wander into other residents' rooms and take their belongings back to her room. Resident #23 took another resident's shoes and put them in her closet, upsetting the resident who looked for her shoes all morning. A progress note dated October 30, 2023 revealed that resident #23 wanders in and out of other residents' rooms and can become agitated and combative with redirection. Review of the facility's five-day written investigation dated October 20, 2023 revealed that on October 16, 2023 at approximately 7:20 p.m., the CNAs in the behavioral unit heard two roommates arguing with each other. They responded to the disturbance and found the residents yelling at each other and arguing over clothes. Resident #23 was topless and going through her roommate's (#47's) closet. The two resident's were close to each other pulling on each other's clothes. The resident's were separated immediately. Resident #47 stated that resident #23 slapped her, but there was witness to the slapping allegation. Both residents' were assessed, and no injuries were found, nor were there any complaints of pain. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's five-day written investigation dated October 20, 2023 also included staff interviews: -a licensed practical nurse (LPN/staff #468), who stated that since the incident, resident #47 acts more defensive when anyone gets near her stuff. He also stated that resident #23 wanders into residents' rooms and grabs stuff. -(CNA/staff #425) stated that resident #23 goes into other residents' rooms and gets into their belongings. -(CNA/staff #407) stated that resident #47 gets upset when people bother her belongings. An interview was conducted on May 22, 2024 at 1:49 p.m. with (CNA/staff #425), who stated that resident #23 has a history of going into everybody's rooms and taking things. Resident #23 was going through resident #47's stuff and they got into it. The residents were pulling on the clothing back and forth. Staff #425 stated that a resident has a right to privacy and she has to always redirect resident's when they are entering another resident's space and resident #47 is possessive of her boundaries and stuff. An interview was conducted on May 22, 2024 at 1:58 p.m. with the Resident Relations Assistant (staff #459), who stated that resident #23 was digging through resident #47's closet and was trying to take it away. She stated that resident#23 has a history of taking other residents' things and staff have reported that resident #23 takes other peoples clothes; staff are supposed to redirect her to another area or activity. Staff #459 stated that a resident has a right to his/her own things, and this includes his/her own personal space. An interview was conducted on May 22, 2024 at 2:29 p.m. with the Director of Nursing (DON/staff #417), who stated that staff are trained on resident rights, which includes the right to privacy. She stated that if one resident has history of taking other peoples' things, it is her expectation that staff redirect the resident when it occurs. This is her plan to protect the other resident's right to privacy, and when monitoring residents who wander, staff should try to keep the resident in a safe environment, and report it to the nurse, so the nurse can assess the resident. The facility policy, Resident Rights dated federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to privacy and confidentiality.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation, policies and procedures, the facility failed to protect the rights of two residents (#50, and #3) to be free from abuse from each other. The deficient practice could result in further abuse of residents and appropriate action not taken. Findings include: Regarding incident involving residents #50 and 191: -Resident #50 (alleged victim) was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, dementia, auditory hallucinations, visual hallucinations, anxiety disorder, and disorientation. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident's cognitive skills for daily decision making is severely impaired. The MDS also indicated that the resident was negative for indicators of psychosis, behavioral symptoms, and wandering during the assessment period. However, the MDS noted that the resident exhibited rejection of care which occurred 1-3 days during the assessment period. An incident note dated October 6, 2023 documented that according to a CNA (certified nursing assistant), this resident yelled at another resident to be quiet. The other resident then approached this resident, told her nobody tells me what to do and slapped her on the left cheek. The note documented that no visible injuries were noted. The note also indicated that the sheriff's department was contacted and informed family, and indicated that resident would be taken to the hospital. A behavior care plan revised on January 24, 2024 revealed that the resident #50 had behavior problems related to the effects of Alzheimer's dementia as evidenced by poor awareness of needed personal care, combativeness, and verbal outburst during personal care. Interventions included to anticipate and meet needs, assist to minimize disruptive behaviors, if issues arise, remove from situation. A care plan revised April 26, 2024 indicated that the resident #50 had impaired cognitive function related to Alzheimer's dementia with impaired thought processes, difficulty making decisions, short term memory loss that is not anticipated to improve. Interventions included supervision/assistance with all decision making, and keep routine consistent. -Resident #191 (alleged perpetrator) was admitted to the facility on [DATE] with diagnoses that included dementia, malignant neoplasm of cerebral meninges, major depressive disorder, and anxiety disorder. A behavior note dated October 5, 2023 indicated documented that the resident was out of the room wandering the halls. The note stated that the resident had been tearful most of the afternoon and upset that her family had dropped her off. Resident was observed to be quickly agitated with loud sounds or voices but was easily redirected. Resident was noted as compliant with medication and care. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A behavior note dated October 6, 2023 documented that a CNA (certified nursing assistant) reported that the resident was pacing, going in to another residents' room and yelling at CNA. The CNA indicated that the resident from room [ROOM NUMBER]-1 called out for the resident to be quiet. Resident #191 then went in to room [ROOM NUMBER]-1 yelled at resident to not tell her what to do then slapped her on the face on the left cheek. The note documented that the CNA assisted resident #191 out of the room at which time the resident continued pacing. The note also documented that 911 was called and that the state agency was notified via after hours number. Additionally, the note indicated that the DON (Director of Nursing) and POA (power of attorney), spouse were notified. An additional behavior note also dated October 6, 2023 documented that resident wandered into other residents' rooms. Resident was noted to become easily angered with other residents when asked to leave their rooms or stop standing behind their chairs at meal times. Another behavior note dated October 7, 2023 stated that CNA reported that resident #191 threw a blanket at her roommate and was yelling, calling her names, telling her to get out of her room. The note also documented that resident #191 grabbed roommates' belongings. Roommate was transferred to another room. Review of the facility's final investigation report dated October 9, 2023 indicated that resident #191 was admitted to the behavioral unit on October 4, 2023. The report indicated that on her second night in the facility, resident #191 was pacing the halls and making noise. She had to be redirected by staff a couple of times. Resident #191 was entering other residents' rooms and yelling at the CNA (certified nursing assistant. The report noted that early Friday morning on October 6, 2023, at approximately 5:50 a.m., she was up wandering the hall being loud. Resident #50 was bothered by this noise and shouted from her bed BE QUIET in Spanish. Resident #191 did not like this, so she entered resident #50's room and yelled at her don't tell me what to do and slapped her on her left cheek. According to the report when the CNA observed resident #191 enter the room, she immediately followed and went in and redirected resident #191 back to the room. However, the CNA was not able to get to resident #191 before the slap occurred. The report indicated that the CNA did witness the event. The report noted that both residents were assessed and no injury was sustained by either resident. Further review of the facility's final investigation report revealed interviews of both residents, other residents, and staff members. Neither one of the residents involved could recall the incident. Additional residents interviewed indicated they felt safe at the facility. The CNA (staff #486) interview stated that she tried to redirect and kept resident away from the perpetrator. Staff #486 indicated that following the incident, resident #50 (alleged victim) had shown more emotions and aggression. Additionally, staff #486 noted that resident #191 (alleged perpetrator) and resident #50 (alleged victim) did not recall the event and ignored each other. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the admission Minimum Data Set (MDS) assessment for resident #191 dated October 10, 2023 revealed that the resident's cognitive skills for daily decision making was severely impaired. The MDS also noted that the resident exhibited hallucinations for indicators of psychosis. The assessment indicated that the resident exhibited physical and verbal behavior symptoms directed toward others which occurred 4-6 days during the assessment period. The resident also exhibited other behavioral symptoms not directed towards others 4-6 days during the assessment period. The MDS assessment revealed that the resident's identified behavioral symptoms placed the resident and others at significant risk for physical injury. The assessment also indicated that the behavioral symptoms significantly interfered with the resident's care. The behavioral symptoms significantly intruded or the privacy or activity of others and significantly disrupted the care or living environment. A care plan initiated on October 17, 2024 indicated that the resident #191 required special care unit related to continued impaired thought process, and unawareness of own safety needs. Interventions included observe for changes in behavior. A behavioral care plan initiated on October 18, 2023 indicated that the resident #191 had a behavior problem related to impaired cognitive function, impaired safety awareness, physical behaviors, verbal behavior, wandering/exit seeking. Interventions included to anticipate needs, identify behavior triggers, and if issues arise, remove from the situation, intervene as necessary to protect the rights and safety of others. A cognition care plan initiated on October 23, 2023 revealed that the resident #191 has impaired cognitive function/dementia or impaired thought processes related to dementia with behaviors, and diagnoses of brain cancer. During an interview with a Certified Nursing Assistant (CNA/staff #463) conducted on May 23, 2024 at 10:37 a.m., staff #463 noted that she was not familiar with resident #191. However, she stated that she was a little familiar with resident #50. She said that the first few days after resident #50 was admitted , she screamed a lot. However, she stated that she had no knowledge about the altercation between the two residents. An interview was conducted with a Licensed Practical Nurse (LPN/staff #479) on May 23, 2024 at 10:55 a.m. Staff #479 stated that resident #191 had behaviors, was confused a lot, and wandered. The LPN also noted that resident #50 was funny and did not have behaviors. Staff #479 stated that she was not aware of any incidents between these two residents. An interview was conducted with the Social Services Manager (staff #459) on May 23, 2024 at 11:53 a.m. Staff #459 stated that she does not remember which resident slapped who in the incident between residents #50, and #191. Regarding incident involving residents #3 and #190: - Resident # 3 (alleged victim) was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included nonrheumatic aortic stenosis, paroxysmal atrial fibrillation, essential hypertension, type 2 diabetes mellitus, and major depressive disorder. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating that the resident #3 was cognitively intact. The MDS also indicated that the resident was negative for indicators of psychosis, behavioral symptoms, rejection of care, and wandering during the assessment period. Review of the care plan did not indicate care planning for behaviors or involvement in any resident-to-resident altercation. A communication note dated June 19, 2023 documented that resident#3 sustained no injury when slapped in the face by former roommate. The note stated that no redness, swelling, or bruising noted. According to the note resident denied pain. The note documented that resident was upset over incident but is stable. The note also indicated that resident understood to keep distance from the other resident going forward. Review of an incident noted dated June 19, 2023 indicated that resident#3 reported being slapped in the face during conversation with another resident. According to the note the resident#3 had gone into the other resident's room to have a conversation regarding allegations of being a liar. The note documented that the other resident became agitated and attempted to leave the room then slapped resident across the face when she did not get out of the way fast enough. A Social Services progress note dated June 19, 2023 stated that it was a late entry from June 14, 2023. The note documented that resident came into office and wanted to discuss issues she was having with roommate. She came in on the 14th but social services was not available. The note indicated that the writer did go to the resident's room and was told resident preferred to discus the next day. Resident came in and discussed issue she was having with roommate. According to the note, resident#3 noted that roommate was calling her a liar and spreading rumors to others. Another incident note dated June 19, 2023 documented that resident #3 was calm without further signs and symptoms of anxiety regarding the resident to resident incident. The note indicated that resident appeared relaxed and went to the dining room for meal and socialization with others. Furthermore, the note stated that there was no complaint of residual pain form incident with the resident stating that I always have some pain but not from this, I'm fine really. A Social Services progress note dated June 20, 2023 indicated another late entry. The note documented that resident#3 is doing well and continued to dine in the dining room for lunch and dinner. The note indicated that the resident still had some sentiment regarding the other resident calling her a liar. The note stated that resident is not approaching the other resident and is being cordial. Resident was requested to discuss with family and friends but not with residents. A nurse practitioner encounter note dated June 21, 2023 documented that resident had a recent altercation with previous roommate. Resident#3 indicated that she was slapped on the face. The indicated that resident had no pain related to the incident. -Resident #190 was admitted to the facility on [DATE] with diagnoses that included hypertensive chronic kidney disease, type 2 diabetes mellitus, dementia, anxiety disorder, and depression. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed that the resident #190 was independent for cognitive skills for daily decision making. Additionally, the MDS indicated that the resident was negative for indicators of psychosis, behavioral symptoms, rejection of care, and wandering during the assessment period. Review of the resident's #190 care plan did not reveal any plan of care related to behavior, mood and or resident to resident altercations at the time of the incident. A therapy note dated June 15, 2023 indicated that the resident#190 scored 11/30 on the SLUMS (St. Louis University Mental Status Examination) which indicated that she had moderate cognitive deficits. The note documented that despite maximum education and encouragement on cognitive therapy, resident declined cognition therapy. The note stated that resident was agreeable to dysphagia treatment. According to the note, the resident complained that she was having great difficulties with quality of life with her current roommate. The note stated that the resident prefers to have a quieter environment and is interested in a room change if possible. A Social Services progress note dated June 19, 2023 indicated a late entry documentation. According to the note the resident#190 was still shook up after the incident. The noted indicated that the resident's account of event changed from the initial explanation to the nurse. The note stated that the resident seemed calmer and noted that she would choose another table to eat at for meals. The resident indicated that she would eat lunch in her room that day. The note stated that it was discussed that it was okay for her to call her close friends and discuss the incident versus speaking with other residents to prevent anxiety. The note indicated that the resident agreed. An incident note dated June 19, 2023 documented that resident#190 had resident to resident altercation in her room. The note stated that resident became agitated and attempted to leave room. According to the note, the resident#190 reported that she attempted to get pass the other resident #3 and that she bumped into something with her arm. The note indicated that resident#190 was noted with 2 skin tears, one to left forearm and one to top of left hand with underlying bruising. The note documented that during the conversation with the resident, she was able to demonstrate the proximity of the altercation, possibly injuring her arm and bruising her leg on the foot board of her bed. The note stated that vital signs were stable after incident with slight anxiety regarding the incident. Another incident note dated June 19, 2023 document that resident#190 remained calm but somewhat anxious regarding the incident. The note indicate that the resident stated I never meant to hit anyone, I'm not like that. The note stated that resident denied pain to left arm and that there was no further sign or symptoms of acute bleeding from skin tears. A nurse practitioner note dated June 21, 2023 documented that a report was received indicating that resident#190 had an altercation with her roommate with some physical aggression. The note stated that no injuries were reported. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation report dated June 23, 2023 revealed that a resident to resident altercation occurred between residents #3 and 190 on June 19, 2023. According to the report resident #190 was lying in her bed sleeping when she was woken up by resident #3 talking to her in a loud and upset voice. The report noted that resident #3 told resident #190 I want to straighten things out. Resident #190 stated that she did not want to talk to resident #3 so she got out of the bed and attempted to leave the room. However, the report noted that resident #3's wheelchair was blocking resident #190's path. The report stated that resident #190 struggled to get around resident #3's wheelchair and slapped resident #3 on the face and made her way around the wheelchair. The report indicated that resident #3 shared room that the week prior, while the two were still roommates, she heard resident #190 say something derogatory about her. This made resident #3 upset and she confronted resident #190 about it. The report stated that resident #190 responded to the accusation stating you're a liar. The report indicated that in between the time of the incident on June 15 and the incident on June 19, resident #3 agreed to a room change. The investigation report noted that resident #3 stated that she had wheeled herself to resident #190's room to return a book she had borrowed and to confront her and set things straight. According to resident #3, while she was talking to resident #190 about the issue, resident #190 got out of the bed and attempted to leave the room. However, since resident #3's wheelchair was blocking the way, resident #190 slapped resident #3 in the face and scooted around her wheelchair. After resident #190 left the room, resident #3 followed resident #190 out of the room and informed a nurse that resident #190 had slapped her. Further review of the facility investigation report revealed a staff interview with a Care Coordinator (staff #438), who stated that residents were separated and social services involved following the incident. Staff #438 indicated that prior to the altercation the residents involved were passive aggressive towards each other. After the incident, the residents appeared anxious. Additionally, staff #438 noted that the alleged perpetrator and victim exhibited behavior of accusations and confrontations that provoked each other. Additionally, the facility investigation revealed that in an interview with the Resident Relations Assistant (staff #459), she noted that prior to the altercation, the residents involved were not friendly with each other. Following the incident, the residents stayed away from each other. During an interview with a Certified Nursing Assistant (CNA/staff #463) conducted on May 23, 2024 at 10:37 a.m., staff #463 stated that resident #3 was a nice lady but did not remember much, she liked to walk around the facility and could get lost but was easily redirected. The CNA stated that resident #190 was sweet but had memory problems. Staff #463 stated that she did not hear about the two residents having an altercation. The CNA said that they identify a resident is at risk for resident to resident altercation when they start making hostile statements and they get a mean/hostile look on their face. Staff #463 noted that when a resident to resident altercation occurs, they separate the residents and report the incident to the nurse, document what happened, and inform other CNAs. The CNA noted that when a resident to resident altercation occurs, the impact on the resident is that it is stressful for the resident that was abused and it causes a change in the resident's schedule. Staff #463 noted that it is important for them to identify those residents at risk for resident to resident altercation to ensure that they do not put those residents with other residents that are also the same in order to prevent incidents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with a Licensed Practical Nurse (LPN/staff #479) on May 23, 2024 at 10:55 a.m. Staff #479 stated that she heard about the incident between residents #3 and #190 but was not sure about the details. The LPN noted that they were roommates at one point. Staff #479 stated that they identify residents as at risk for resident to resident altercation based on their behaviors. When a resident to resident altercation occurs, the residents are separated, the DON (Director of Nursing, administrator provider, family, and police are notified, assessments are completed and behaviors documented. Staff #479 noted that the impact on residents when a resident to resident altercation occurs is that the residents can have increased anxiety, they exhibit withdrawal/sadness/negativity/loss of appetite. The LPN stated that it is important to identify those at risk for resident to resident altercation since they are at higher risk for confrontation and therefore have to be watched so that behaviors can be communicated and incident prevented. An interview was conducted with the Social Services Manager (staff #459) on May 23, 2024 at 11:53 a.m. Staff #459 noted that residents #3 and #190 were roommates. She indicated that what she recalled about the incident between the two residents was that resident #190 was saying stuff/spreading rumors in the dining room area and resident #3 heard it and addressed it. Staff #459 said that resident #3 went to resident #190's room by her bed and blocked resident #190. Resident #190 slapped resident #3 resulting in a red mark on her face. Resident #190 hurt herself on the dresser as she was attempting to leave the room. Staff #459 noted that her role during abuse allegations is that she gathers preliminary information and provides it to the Executive Director (E.D.) so that he would know how to proceed. She noted that in instances of abuse, they interview 5 employees and 5 residents. The employees selected for interview are those that worked during the timeframe of the alleged incident and whoever would be knowledgeable about the incident. The residents selected for interview are those that were in the area or were witness to the incident. During an interview with the Director of Nursing (DON/staff #417) conducted on May 23, 2024 at 12:48 p.m., she stated that that her expectation is that staff reports incidents of resident to resident altercations and place interventions in order to prevent further incidents. Staff #417 stated that following a resident to resident altercation, the incident should be reported to the DON and administrator and ensure the safety of both residents and the entire unit. Review of the facility policy titled Abuse Policy version 0622, revealed that the facility strives to prevent the abuse of all their residents. The policy also noted that the resident suspected of being abused will be monitored and placed on alert charting.

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	035073	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven Health Green Valley, LLC	150 North LA Canada Drive Green Valley, AZ 85614

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that two residents (#75 , #241) were assessed, monitored and had orders for self-administration of medications and that one resident (#23) was monitored with appropriate level of supervision. The deficient practice could result in residents being injured. Findings include Resident #23 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, hypertensive chronic kidney disease, anxiety disorder, and a major depressive disorder. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 3 indicating the resident had a severe cognitive impairment. Review of the the care plan dated September 12, 2023 revealed a behavior care plan related to dementia as evidenced by impaired safety awareness, physical behaviors, resistive to care, verbal behaviors, and wandering/exit seeking. Interventions included to administer medications as ordered, anticipate and meet the resident's needs, and encourage as much participation/interaction as possible during care activities. A behavior progress note dated September 16, 2023 revealed that a resident was restless, wandering/pacing the halls, and exit seeking. The resident was also noted hoarding objects in pockets and was difficult to redirect. A behavior progress note dated September 28, 2023 revealed that the resident was noted wandering into another resident's room this afternoon. The other resident became agitated and insisted that the resident leave. Staff was able to redirect both residents. Staff reported that the resident continues hoarding everyday objects in her purse, closet, and dresser drawers including dirty pull-ups. A progress note dated October 7, 2023 revealed that resident #23 was transferred to another room due to not getting along with her roommate. A progress note dated October 16, 2023 revealed that a nurse was called into the unit due to a resident-to-resident confrontation. Residents were heard yelling at each other in their room and the certified nursing assistants (CNAs) went into the room where residents were found arguing and pulling on each other's clothes. The roommate (#47) was upset because resident #23 was rummaging through her closet. Resident #47 stated that resident #23 slapped her. The residents were separated and one was moved to another room to prevent any further altercations. Both residents were assessed by the nurse and no injuries or marks were noted, vital signs were stable, and no complaints of pain from either resident. A progress note dated October 18, 2023 at 11:47 a.m. revealed that resident #23 continues to wander into other residents' rooms and take their belongings back to her room. Resident #23 took another resident's shoes and put them in her closet, upsetting the resident who looked for her shoes all morning. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated October 30, 2023 revealed that resident #23 wanders in and out of other residents' rooms and can become agitated and combative with redirection. -Resident #47 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia with other behavioral disturbance, adjustment disorder, and major depressive disorder. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 6 indicating the resident had a severe cognitive impairment. Review of the the care plan dated February 14, 2023 revealed a behavior care plan related to related to impaired cognition as evidenced by verbal aggression toward staff, rejecting needed care, yelling at staff, and obsessing over particular items. A progress note dated October 11, 2023 revealed that the resident gets easily irritated with other residents and staff, yells out and is often impulsive. A behavior health service provider is present in the facility and advised. A progress note dated October 16, 2023 revealed that a nurse was called into the unit due to a resident-to-resident confrontation. Residents were heard yelling at each other in their room and the certified nursing assistants (CNAs) went into the room where residents were found arguing and pulling on each other's clothes. The roommate (#47) was upset because resident #23 was rummaging through her closet. Resident #47 stated that resident #23 slapped her. The residents were separated and one was moved to another room to prevent any further altercations. Both residents were assessed by the nurse and no injuries or marks were noted, vital signs were stable, and no complaints of pain from either resident. A physician's note dated October 23, 2023 included that resident #47 recently had an altercation with another resident. Both residents were yelling at each other and arguing about clothes. Resident #47 reported that she was slapped by the other resident. The incident was unwitnessed and there were no signs of injuries reported by nursing staff. Review of the facility's five-day written investigation dated October 20, 2023 revealed that on October 16, 2023 at approximately 7:20 p.m., the CNAs in the behavioral unit heard two roommates arguing with each other. They responded to the disturbance and found the residents yelling at each other and arguing over clothes. Resident #23 was topless and going through her roommate's (#47's) closet. The two resident's were close to each other pulling on each other's clothes. The resident's were separated immediately. Resident #47 stated that resident #23 slapped her, but there was witness to the slapping allegation. Both residents' were assessed, and no injuries were found, nor were there any complaints of pain. Review of the facility's five-day written investigation dated October 20, 2023 also included staff interviews: -a licensed practical nurse (LPN/staff #468), who stated that since the incident, resident #47 acts more defensive when anyone gets near her stuff. He also stated that resident #23 wanders into residents' rooms and grabs stuff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-(CNA/staff #425) stated that resident #23 goes into other residents' rooms and gets into their belongings. -(CNA/staff #407) stated that resident #47 gets upset when people bother her belongings. An interview was conducted on May 22, 2024 at 1:49 p.m. with (CNA/staff #425), who stated that resident #23 has a history of going into everybody's rooms and taking things. Resident #23 was going through resident #47's stuff and they got into it. Staff #425 stated that a resident has a right to privacy and she has to always redirect resident's when they are entering another resident's space and resident #47 is possessive of her boundaries and stuff. An interview was conducted on May 22, 2024 at 1:58 p.m. with the Resident Relations Assistant (staff #459), who stated that resident #23 was digging through resident #47's closet and was trying to take it away. She stated that resident#23 has a history of taking other residents' things and staff have reported that resident #23 takes other peoples clothes; staff are supposed to redirect her to another area or activity. Staff #459 stated that a resident has a right to his/her own things, and this includes his/her own personal space. An interview was conducted on May 22, 2024 at 2:29 p.m. with the Director of Nursing (DON/staff #417), who stated that staff are trained on resident rights, which includes the right to privacy. She stated that if one resident has history of taking other peoples' things, it is her expectation that staff redirect the resident when it occurs. This is her plan to protect the other resident's right to privacy, and when monitoring residents who wander, staff should try to keep the resident in a safe environment, and report it to the nurse, so the nurse can assess the resident. Regarding Resident #241: Resident #241 was admitted on [DATE] with diagnosis including atherosclerotic heart disease of the native coronary artery, chronic atrial fibrillation, essential hypertension, chronic obstructive pulmonary disease, obstructive sleep apnea, hypertensive heart disease with heart failure, pleural effusion, cardiomegaly, atelectasis, cirrhosis of the liver, hypo-osmolarity and hyponatremia, fracture of T7-T8 vertebra, wedge compression fracture of the second lumbar vertebra, diverticulosis, abdominal aortic aneurysm, obstructive and reflux uropathy, type II diabetes, major depressive disorder-recurrent, constipation, and muscle spasms. The admission MDS (minimum data set) was noted to be in progress. A review of the physician orders, revealed no evidence of an order for Orajel or an order for self-administration of medication. A review of the electronic medical record revealed no evidence of an assessment for self-administration of medications. A review of the care plan for resident #241 revealed no evidence of medication self-administration. A review of the progress notes revealed no evidence that the resident had been assessed for self-administration of medication. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was conducted on May 20, 2024 at 10:37 A.M. A tube of Orajel was observed at bedside for resident #241. The resident's spouse, who was present at the time of observation, stated that the resident has gum pain and that she had brought the medication from home. She further stated that nursing staff were aware of the medication and had seen it when it was brought in. An observation was conducted on May 20, 2024 at 1:40 P.M. It was observed that Orajel was still on the resident's bedside table in plain view. An observation was conducted on May 21, 2024 at 7:40 A.M. It was observed that Orajel was still on the resident's bedside table. Regarding Resident #75: Resident #75 was admitted on [DATE] with diagnosis including traumatic subdural hemorrhage , traumatic subarachnoid hemorrhage, traumatic hemorrhage of cerebrum, acute transverse myelitis in demyelinating disease of the central nervous system, ataxic gait, hypertension, hyperlipidemia, fibromyalgia, peripheral vascular disease, chronic pain syndrome, urinary incontinence, retention of urine, peripheral vascular angioplasty with implants and grafts, atrial fibrillation, convulsions, seasonal allergic rhinitis, lack of coordination, cognitive communication deficit, weakness, unsteadiness, abnormalities of gait and mobility, mild protein-calorie malnutrition, neuromuscular dysfunction, and displaced bimalleolar fracture of the right lower leg. A review of the MDS dated [DATE] revealed a BIMS (brief interview of mental status) score of 12, suggesting mild cognitive impairment. A review of the physician orders revealed no evidence of an order for Voltaren, Flonase or for self-administration of medication. A review of the care plan for resident #75 revealed no evidence noting self-administration of medication. A review of the progress notes revealed no evidence that the resident had been assessed for self-administration of medication. An observation was conducted on May 20, 2024 at 10:22 A.M. It was observed that Flonase 50mcg and Voltaren 2.32% were on the resident's bedside table. An observation was conducted on May 20, 2024 at 1:41 P.M. It was observed that both medications were still located on the resident's bedside table. An observation was conducted on May 21, 2024 at 7:41 A.M. It was observed that Voltaren was still on the resident's bedside table; however, Flonase was no longer visible. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on May 21, 2024 at 7:48 A.M. with staff #452, CNA (certified nursing assistant). Staff #452 stated a medication is anything what nurses give to patients, including: oral, inhalants, eye drops, intravenous or any over the counter medications. Any medications given to a resident have to be prescribed by the doctor and need to include the amount and frequency of the medication. Staff #452 stated that residents can't have a medication at bedside unless it's prescribed. She stated that the risk of having medications that are not prescribed at bedside can include overdose. An interview was conducted on May21, 2024 at 7:55 A.M. with staff #508, RN (registered nurse). Staff #508 stated medications can include pretty much anything, including creams, ointments, vitamins, and eye drops. Staff # stated that medications are not allowed at bedside unless prescribed and assessed for safety. Staff #508 stated that she checks for medications in resident rooms every day. Staff #508 stated that risk of unauthorized medications at bedside could include other residents accidentally picking up the medication and using it. An interview was conducted on May 21, 2024 at 8:03 A.M. with staff #417, DON (director of nursing). Staff #417 stated that residents are not able to have medications at bedside unless they have been assessed and a physician order for the medication is in place. Staff #417 stated that if medications are brought in by the residents or family, they are removed by nursing staff for safe keeping in a secure place and labeled with the resident's name. Staff #417 stated that the expectation is residents are assessed for ability and safety to self-administer medications and that orders are in place for any medications at bedside. Staff #417 stated that the risk could include duplication of medication and or other confused patients could wander into the room and take-off with it. The facility policy entitled Medications: Self-Administration of Medications dated January 1, 2024 revealed that as part of the evaluation comprehensive assessment, the interdisciplinary team assesses each resident's cognitive and physical abilities to determine whether self-administration of medications is safe and clinically appropriate for the resident. The policy further stated that if a resident is deemed safe and appropriate to self-administer medications, it is documented in the medical record and care plan; however, no evidence of documented assessment was evident in the care plan or the medical record as a whole. The facility policy, Resident Safety: Safety and Supervision of Residents dated January 1, 2024 states that the facility's individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.