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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911 Based on resident and staff interviews, review of the clinical record, facility documentation and policy, the facility failed to ensure that code status was accurate and consistent in the medical record for one resident, #242. The deficient practice could result in resident not receiving care consistent with their signed advance directive. Findings include: Resident #242 was admitted on [DATE] with diagnosis including hypotension, hypertension, presence of a cardiac pacemaker, major depressive disorder-recurrent, obstructive and reflux uropathy, diverticulitis of large intestine and edema. A review of the MDS (minimum data set) revealed that the admission MDS was still noted to be in progress. A review of the physician orders dated May 15, 2024, revealed that the resident was a full-code, meaning that cardiopulmonary resuscitation and other resuscitation procedures should be used to keep the resident alive. A review of the care plan, dated May 16, 2024, revealed that the resident's advanced directives were in effect. Further stating that the resident's wishes should be carried out in accordance with her advanced directives and to ensure that her wishes are recorded correctly in her chart and follow physician orders. The primary landing page in the resident's electronic health record, at the top of the page, noted the resident to be a full-code. Further review of the electronic health record for resident #242 revealed that the resident had signed for DNR (do not resuscitate) on May 15, 2024. (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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F 0578 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 that staff are able to locate a resident's code status in the electronic health record. She stated that the code status can be found on the top of the landing page in the electronic health record. Staff #452 pulled up the record for resident #242 and when asked, stated that resident #242 was noted to be a full-code. She stated that the expectation is that information in the record is accurate, and if for some reason it isn't, then it could be a problem for the facility as they would be going against the resident's wishes. An interview was conducted on May 21, 2024 at 7:55 A.M. with staff #508, RN (registered nurse). Staff #508 stated that the advanced directives are generally done by the admitting nurse. She stated that the nurse would review everything on the form with the resident to ensure that the resident understands what they are selecting and signing. Staff #508 stated that if the DNR option was selected, then the resident would sign the orange DNR form, which is then uploaded into the resident's electronic medical record. She stated that if it was necessary to obtain the code a specific resident, staff would first look in the electronic record to determine the code status. She stated that the DNR form is also available in hard copy on the unit, but it's generally a lot quicker to look in the electronic record. Staff #508 pulled up the electronic health record for resident #242 and stated that this resident is a full code. When staff #508 was asked to pull up the actual DNR document, she stated that the resident should actually be a DNR. An interview was conducted on May 21, 2024 at 8:03 A.M. with staff #417, DON (director of nursing). Staff #417 stated that staff will try to get the advanced directives completed on admission, but if the resident is unable to make the decision, then staff will attempt to reach the authorized representative and the resident will be a full code, until the advanced directive or DNR form can be signed. Staff #417 stated that there is a binder on each nurses station where the paper DNR's are housed, additionally the advanced directive/ DNR is noted in the electronic health record at the top of the page. She stated, to ensure the accuracy of the records regarding advanced directives/ DNR's, medical records perform an audit process. Staff #417 pulled up the electronic health record for resident #242 and stated that the resident was a full-code, based on the record and physician orders; however, when asked to review the actually documentation that the resident had signed, she stated that the resident had a DNR in place. Staff #417 stated that her expectation is that the form, orders and entry in the electronic health records match, which she stated they did not for resident #242. She stated that the risk is, if a resident 'coded', staff would likely look in the electronic health record first to initiate the code and if that information is incorrect, then the resident's wishes would not be followed. Staff #417 stated that she would immediately have the orders changed. A review of the facility policy entitled Advanced Directives revised April 2013 revealed that advanced directives will be respected in accordance with state law and facility policy. The policy further indicated that the plan of care for each resident will be consistent with the resident's treatment preferences and or advanced directives.

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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 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** 40581 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. 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. (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 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. Review of the facility's five-day written investigation dated October 20, 2023 also included staff interviews: (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on observations, staff interviews, and the facility policy and procedures, the facility failed to ensure that floor tiles, laminate flooring, shower drain, and door frame in common areas were safe for residents ambulating and showering. The deficient practice could result in residents falling and/or being injured. Findings include: On May 21, 2024 at 4:23 p.m., a walk through of the facility was conducted and the following environmental issues were observed: -one rectangular panel of the laminate flooring in Hall 100, between rooms #127 and #128, was broken and approximately half an inch was missing from one of the corners of the laminate. -the laminate panel in the doorway of room [ROOM NUMBER] was observed to have approximately 16.5 inches in length broken and missing. -six tiles in Hall 100 were cracked and/or broken. -the transition strip between the laminate flooring and the tile flooring on Hall 100 by room [ROOM NUMBER] was cracked in multiple areas. -in the hallway, near room [ROOM NUMBER] a piece of the flooring, circular in shape, was compressed, so that the floor was uneven and there was cracked and broken laminate around the circumference of the circle. -one rectangular laminate floor panel located near room [ROOM NUMBER] on Hall 100 was not secured to the floor. -there was no transition strip between the tile and the laminate flooring toward the end of Hall 100 by room [ROOM NUMBER]. -the drain in the bathroom shower on Hall 100 was approximately two inches in diameter and there was a square silver drain cover only partially covering the round open hole and the drain cover was not attached to the floor. -the doorframe of the bathroom on Hall 100 had areas were paint was missing and a brown rust color was observed. -upon entering the secured unit on Hall 100, one rectangular laminate floor panel was broken with approximately 3 inches by 1 inch of the panel missing. -in the hallway of the secured unit on Hall 100, a circular shape, approximately three inches in diameter, was compressed, so that the floor was uneven. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-by the left door to the main dining room, the Azelea room, there were two eighteen by eighteen inch tiles broken and cracked. -by the right door to the main dining room, the Azelea room, the tile was not flush/even with the surrounding tiles, creating a dip of approximately one centimeter where residents would enter the dining room. -there was no transition strip between the tile and the laminate flooring near room [ROOM NUMBER] on Hall 200. An interview was conducted on May 22, 2024 at 8:37 a.m. with the Maintenance Manager (staff #430), who stated that anyone can put in a request for a repair and he prioritizes repairs based on resident safety, how it impacts the residents' stay, and anything to do with safety, should be repaired immediately. He stated that safety risks included falls and could include rust if the resident came into contact with the rust. He stated that he inspects the facility daily, and that he has laminate flooring, transition strips, and paint in stock. He stated that drain covers should be screwed down to make sure that the drain is covered. He also, stated that he has a company credit card and can purchase supplies when needed to make repairs. During the interview, a walk through the facility was conducted, so staff #430 could observe the above issues. He acknowledged that the uneven and broken flooring could be a fall risk for the residents and he had noticed the circular compressions in the floor sometime in the last six months. It was observed that he had begun fixing some of the tiles on Hall 100 by filling the broken and cracked areas with resin. He stated that he had removed the transition strip and would be replacing it before the end of the day. At approximately 9:21 a.m., the Environmental Engineer (staff #611) joined the interview. Staff #611 stated that he thought the circular compressions in the floor were a result of the drain below the flooring and the unevenness of the floor could be fixed. Staff #611 viewed the brown rust color on the bathroom doorframe on Hall 100 and stated that it was rust and could cause an infection to residents. He also acknowledged residents could be injured because the drain cover was bit secured to the shower floor. An interview was conducted on May 23, 2024 at 11:06 a.m. with the Administrator (staff #605), who stated that he supervises the maintenance department and was updated about the floors. He has been trying to fix the floor in the residents' rooms as needed and thinks some of the flooring in the facility is a potential risk for safety. It is expectation that staff put in requests for repairs and the repairs are done daily/weekly. The facility policy, Resident Safety: Safety and Supervision of Residents dated January 1, 2024 states that the facility strives to make the environment as free from accident hazards as possible. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes. The Maintenance Manager job description states that the Maintenance Manager must have knowledge of all areas facility maintenance and is responsible for the maintenance of the physical environment, including offices, common areas, and resident rooms.

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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** 46606 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 readmitted 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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	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 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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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on documentation, staff interviews, and the facility policy and procedure, the facility failed to complete the Preadmission Screening and Resident Review (PASRR) Level I for one resident (#24), and failed to submit the PASRR Level II to the state agency. The deficient practice could result in residents not receiving additional services that are needed. Findings include: Resident #24 was admitted to the facility on [DATE] with diagnoses that included schizophrenia unspecified, bipolar disorder, and Parkinsonism. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 11 indicating the resident had a moderate cognitive impairment. Review of the PASRR Level I dated June 6, 2023 did not reveal any serious mental illnesses, anti-psychotic medication, or assessment for substantial functional limitations. Due to the form not being completed, it was not submitted to the state agency for a PASRR Level II. Review of the care plan dated June 12, 2023 revealed that the resident uses anti-psychotic medications (Haldol) related to a diagnosis of schizophrenia as evidenced by episodes of verbal agitation and physical aggression. Interventions included to administer medications as ordered and monitor for side effects and/or toxic symptoms. Review of the care plan dated June 27, 2023 revealed that the resident has episodes of impaired cognitive function or impaired thought processes related to schizophrenia-bipolar disorder as evidenced by short term memory loss, and episodes of miscommunication related to hearing impairment. Interventions included to provide the resident with necessary cues, stop and return if the resident is agitated and to engage the resident in simple, structured activities that avoid overly demanding tasks. An interview was conducted on May 21, 2024 at 8:28 a.m. with the Resident Relations Manager (staff #473), who stated that she checks the PASRR Level I and it is updated after 30 days as per the regulation. She reviewed the clinical record and stated that the resident was admitted to long-term care, so the PASRR Level I should have been updated. She also acknowledged that the resident had a diagnoses of schizophrenia and a bipolar disorder, so the PASRR Level II should have been submitted to the state agency. She reviewed documentation with medical records and stated that she did not have a completed PASRR Level I for the resident. An interview was completed on May 22, 2024 at 2:40 p.m. with the Director of Nursing (DON/staff #417), who stated that it is her expectation that the PASRR is reviewed by staff #473 if the resident is going to stay more than 30 days. If the resident has an appropriate diagnoses, staff #473 should submit the PASRR Level I to the state agency. the PASRR Level two agrees that the purpose is to determine that the facility meets the needs of the resident and if additional services are needed. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Pre-Admission Screening and Resident Review (PASRR) states that our facility will strive to verify that a Level I PASRR Screening has been conducted, in order to identify serious mental Illness (MI) and/or an intellectual disability (ID) prior to initial admission of Individuals to the facility. If the resident is positive for potential MI or ID, a Level II PASRR referral must be submitted. It Is the responsibility of the facility to make referrals for a Level II PASRR, or in some cases, to ensure the referral Is made by the Arizona Long-Term Care (ALTCs) case manager, if a Level II PASRR Is determined to be necessary.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606 Based on observation, interviews and policy review, the facility failed to ensure that physician's orders was followed regarding one resident's (#31) AV (arteriovenous) fistula. The deficient practice could result in the resident's AV fistula failing. Findings include: Resident #31 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease, hypertensive chronic kidney disease, Parkinsonism, atherosclerotic heart disease of native coronary artery without angina pectoris, paroxysmal atrial fibrillation, and dependence on renal dialysis. Review of the order summary report revealed a physician order dated June 5, 2018 which indicated No Blood pressure or venipuncture to AV fistula site every shift for left arm. A care plan initiated on June 28, 2018 and revised on March 2, 2023 indicated that resident needs dialysis related to end stage renal failure. The goal was that the resident would not have signs and symptoms of complications from dialysis. Interventions included: Do not draw blood or take B/P (blood pressure) in left arm with graft, and check and change dressing daily at access site. However, review of the resident's blood pressure (BP) log over the last six months revealed that it was taken on the left arm on the following dates: - December 11, 2023 - December 18, 2023 - January 1, 2024 - May 13, 2024 Further review of the BP log revealed numerous occasions since the resident was admitted in which her BP was taken on the left arm. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating that the resident was cognitively intact. The MDS assessment also noted that the resident receives hemodialysis treatment. The assessment also indicated that the resident is dependent to renal dialysis. An interview with a Certified Nursing Assistant (CNA/staff #510) was conducted on May 22, 2024 at 4:19 p. m. Staff #510 stated that for residents on dialysis, you use the opposite arm to take BP. The CNA said that you do not take the BP on the arm with the fistula. Staff #510 noted that the nurse normally informs CNAs not to take the BP on the same arm as the fistula site. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with a Licensed Practical Nurse (LPN/staff #513) conducted on May 22, 2024 at 4:32 p. m., staff #513 stated that you cannot take vitals on the same site as the fistula. The LPN noted that you want to check for bruit and thrill on the fistula site and do a skin assessment. An observation was conducted on May 23, 2024 at 9:49 a.m. During the observation the CNA (staff #462) accomplished hand hygiene, wiped/disinfected the vitals machine then took resident #31's vitals. Staff #462 explained that the reason she was using resident #31's right arm is due to her having a fistula on the left arm. An interview with the Director of Nursing (DON/staff #417) was conducted on May 23, 2024 at 9:49 a.m. Staff #417 stated that her expectation is that staff will take bp on the arm with the fistula before and after dialysis. The DON noted that she expects for staff to follow physician's orders when caring/treating residents. Staff #417 said that not following physician's orders with regards to not taking bp on the arm with the fistula could damage the fistula. The DON indicated that pre-dialysis vitals are inputted on Point of Care (POC) and includes temperature, pulse, bp, and weight. Staff #417 stated that staff do not have to document which arm they take the bp on since they do not take it on the fistula side. The DON noted that they run with consistent staff and it is communicated to CNAs not to take bp on side with the fistula. In the case of resident #31 if her fistula is on the left then bp should be taken on the right arm. Staff #417 stated that she does not know how the nurse knows that the bp is being taken on the appropriate arm. The facility policy titled End-Stage Renal Disease, Care of a Resident with revised September 2010, stated that residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. The policy noted that staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. Education and training of staff includes, the care of grafts and fistulas. Furthermore, the policy noted that the resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care. Review of the facility policy titled Documentation: Charting and Documentation in effect on January 1, 2024, indicated that 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. Additionally, the policy noted that documentation in the medical record will be objective, complete, and accurate.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 47911 Based on personnel file review, staff interview, and facility documentation and policy review, the facility failed to ensure the activities program was directed by a qualified professional. The deficient practice could result in the activities provided not meeting the assessed needs of the residents. Findings Include: A review of the personnel file for the role of activity manager (staff #432) was conducted on May 21, 2024. However, review of file did not reveal evidence that staff #432 possessed the qualifications required for the role of activities director. An interview was conducted on May 21, 2024 at 1:12 P.M. with staff #498, human resource manager. Staff #498 stated that the role of activity manager had no additional qualifications needed beyond the scope of qualifications that staff #432 had. She stated that the facility did not require licensure or registration for the activity manager. An interview was conducted on May 21, 2024 at 2:14 P.M. with staff #605 , administrator. Staff #605 stated that he was aware that the current activities director was not licensed or registered, but stated that staff #432 was in the process and getting ready to test soon. He further stated that the facility already had a performance improvement plan in place and that the Occupational Therapist, staff #536 was currently supervising the activities director since January 2024 until her licensing/ registration has been completed. An interview was conducted on May 22, 2024 at 8:03 A.M. with staff #432, activity manager. Staff #432 stated that she was the activity manager and that she had 4 additional staff members assisting in the activities department. She stated that she had initially started with the facility by working in the kitchen for 3 years and then had worked as an activity assistant for 2 years and further stated that she had been in the role of activity manager for 7 years. Staff #432 stated that she was certified at one point, but had lost the certification 2 years ago. She stated that she had been working on recertification and was scheduled to test on May 24, 2024. She stated that she had maintained her continuing education requirements in spite of not being certified. Additionally, staff #432 stated that she had maintained her active membership with the Arizona state professional's organization for activity directors. She stated that her current activity calendars were being reviewed by the therapy department, but could not recall when this process had started. She stated that there 2 therapist providing oversight, one was staff #533 and she was unable to recall the name or appearance of the other therapist, who was later identified as staff #536. She stated that staff #533 would review her calendar and at times make recommendations as they pertain to tasks involving therapy. (continued on next page)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on May 22, 2024 at 8:22 A.M. with staff #533, PTA (Physical Therapy Assistant). Staff #533 stated that there is coordination between activities and therapy regarding outdoor activities and getting in or out of activities. He stated that he was not the supervisor for staff #432. He stated that he likes to look at the ideas the activity department brings forward and reviews them for safety. However, he stated that he only reviews the calendar and nothing else. He stated that he started reviewing the calendars in October of 2023. He further stated that the other staff member providing additional oversight was staff #536. An interview was conducted on May 22, 2024 at 8:28 A.M. with staff #536, OT (occupational therapist). Staff #536 stated that he had been checking on how the activities program is run and was involved in coordinating the program with the current activity's director. He stated that he was meeting with the activity manager approximately every two weeks, since the day he started with the facility back in April of 2024. An interview was conducted on May 22, 2024 at 10:03 A.M. with staff #605 (administrator). Staff #605 stated that he was uncertain when the activity manager licensure/ certification had lapsed. He stated that it was an identified deficiency when a home office audit was conducted at the beginning of the year. He further stated that he was unsure of the exact date when the OT started providing the oversight for the activity manager. Staff #605 further stated that his expectation is that staff who require licensure and or registration should never have it lapse. He stated that the risk for not having a licensed and or registered activity manager could include the scheduling of activities that might be inappropriate for the residents. A review of the facility policy entitled Hiring and Rehiring Employees dated January 1, 2024 revealed that the company policy is to hire qualified applicants. The policy further states that in order to qualify for a position, the facility looks at eligibility, qualifications, skills, attitude, dependability, cooperation and other legitimate business considerations. A review of the policy entitled Administrative Policies: Licensure, certification and registration of personnel dated January 1, 2024 revealed that personnel who require a license, certification or registration to perform their duties must present verification of the aforementioned to the human resources director/ designee prior to or upon employment.

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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** 40581 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. (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 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. -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: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-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. 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. 47911 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606 Based on clinical record review, staff interviews, and review of facility policy and procedure, the facility failed to ensure dental needs were met for one sampled resident (#41). The deficient practice could result in residents not receiving care and services for oral/dental conditions. Findings include: Resident # 41 was initially admitted to the facility on [DATE] with diagnoses that included hemiplegia, hemiparesis, dysphagia, atherosclerotic heart disease, hypertensive heart disease, chronic diastolic heart failure, and chronic obstructive pulmonary disease. A dental note dated September 8, 2022 revealed that a consultation visit was completed. The findings/recommendations was ext (extraction) of #26 (lateral incisor), 27 (cuspid), and 28 (first bicuspid). The next schedule appointment was marked as October 5, 2022. However, further review of dental referral notes did not reveal any documentation of that visit or if that visit occurred. A care plan initiated on February 28, 2023 revealed that the resident is at risk for acute oral/dental health problems related to missing and/or cavity prone teeth. Interventions included coordinate arrangements for dental care, transportation as needed/as ordered. Review of dental noted dated January 2, 2024 indicated that an initial exam was conducted and found that resident had broken teeth. During the exam it was discovered that resident had a worn FUD (full upper denture) for over 3 years and never had lower dentures. It was noted that FUD fit loosely and needs adhesive for retention. The note indicated that recommended treatment included surgical exts (extraction) #26 (lateral incisor), 27 (cuspid), 28 (first bicuspid), and 29 (second bicuspid); and FUD/FLD (full lower denture). Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating that the resident was cognitively intact. The MDS also documented that the resident had obvious or like cavity or broken natural teeth. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Unit Secretary (staff #424) was conducted on May 23, 2024 at 9:19 a.m. Staff #424 stated that nurse or providers informs her which residents need dental services. For new residents they sent the face sheet to the dental provider, for long term care residents, if they do not know if Medicare covers, they call the dental office to ask if they cover and if the dentist is contracted. One of the dental providers comes in and provides dental services and the other will send a list and they let her know which residents needs to be seen. Staff #424 noted that the process for scheduling is usually via email contact initiated by her. For example, if a resident has an appointment today, she annotates it then the day after, she calls and checks if the resident has a follow-up appointment. Regarding resident #41, her name was not on list prior to the dental provider coming in today. Looking at the chart, staff #424 stated that she does not see anything else in reference to resident #41 seeing dental services other than the initial visit in January 2, 2024 and the one prior to that was with another dental provider back in September 8, 2022. The Unit Secretary stated that she would need to ask Medical Records to see if there are any other appointment dates. Review of an email thread between the Unit Secretary (staff #424) and the Dental Office Manager (staff #620) dated May 23, 2024 revealed that resident #41 does not have any current scheduled appointment. Staff #620 indicated that they will be scheduling resident #41 in two to three weeks. During an interview with the MDS Coordinator/Care Coordinator (staff #415) conducted on May 23, 2024 at 10:10 a.m., staff #415 stated that during assessment if oral/dental issues is noticed, the resident is sent for dental services and dietary gets involved to adjust based on needs. Speech also does an eval when resident is first admitted and if they see something pertinent then dental services is also set up. The MDS and Care Coordinator stated Social Services is notified and they relay to them if resident has obvious cavity, broken teeth, pain or trouble swallowing. Usually Social Services will set up the appointment. Staff #415 stated that every 3 months there is a quarterly assessment and they note if there are changes. If a big issue is noticed with oral/dental then let Social Services know. Staff #415 noted that they also ask CNAs if there are any changes and if residents are eating okay. An interview was with resident #41 was conducted on May 23, 2024 at 10:49 a.m. Resident #41 pointed at her remaining teeth and stated that she has pain in the areas she is pointing to. She said that she does have dentures but they are temporary ones. Resident #41 said she has 3 teeth left in the lower. They looked decayed and needs attention/extracted. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON/staff #417) conducted on May 23, 2024 at 12:47 p.m., staff #417 stated that residents are seen by the dentist per facility protocol, family approval of cost, transportation, and if any pain or dental issues are noted, and per dentist recommendation. The DON noted that family can refuse cost. The facility tries to see if there is anything through insurance for additional coverage, donated funds, share of cost money to get payment plan for dentist. Family and Social Services is contacted if they need assistance getting dental care/paying for dental care. The DON stated that dental notes are faxed and scanned into the resident's records. Staff #417 said that she believes routine dental care is yearly but in the public setting, they try to go every six months but she does not know what the frequency is that residents needs to be seen. The DON indicated that if a resident needs follow-up services, receptionist will keep a list of needed follow-up and Social Services is involved in coordination and care conferences which the family attends. Dental issues are expected to be brought up during care conferences. She stated that she expects for provider to be notified and an order sent to the Social Services and scheduler to work on getting the resident a dental appointment. There should be a follow-up dentist note. She stated that for the annual there is no tracking system but there is if it is about a follow-up appointment. During the dental exam, dental issues would be addressed. An order is generated for dental. There is a batch order which allows to schedule without needing doctor's orders but if the resident has pain then the provider has to be notified. Staff #417 said that the impact of resident not getting dental services is potential weight loss, infection, and pain. Review of the facility policy titled Personal Care: Dental Services effective January 1, 2024, indicated that routine and emergency dental services are available to meet the resident's oral health in accordance with the resident's assessment and plan of care. Additionally, it noted that social services representatives will assist residents with appointments and transportation arrange