STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035118	A. BUILDING _____ B. WING _____	**03/28/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF CAMP VERDE	**86 WEST SALT MINE ROAD CAMP VERDE, AZ 86322**

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 0600 **Level of harm -** 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 reviews, staff interviews, facility documentation and policy and procedures, the facility failed to ensure one resident (#292) was free from neglect, by staff performing an unsafe transfer causing a fall, which resulted in psychological harm to the resident. The facility also failed to ensure 4 out of 5 sampled residents (#'s 3, 16, 244 and 292) were free from abuse. The deficient practice resulted in one resident being fearful of falling, causing psychological distress and anxious behaviors, which resulted in an overall decline. The deficient practice also resulted in four residents being subjected to abuse. Findings include: -Resident #292 was admitted to the facility on (MONTH) 11, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 27, (YEAR). Regarding an incident of neglect: Review of the baseline care plan-admission evaluation dated (MONTH) 11, (YEAR) under the section for ADL's (activities of daily living), revealed that resident #292 was alert and oriented x 4 and was totally dependent on two staff with transfers. The documentation included the resident had severe impairment with movement to bilateral legs and hips. Review of the ADL care plan dated (MONTH) 13, (YEAR), revealed the resident had an ADL self-care performance deficit, related to deconditioning. One of the interventions included that staff participation was required for transfers. However, the care plan did not specify how many staff were required for transfers or if mechanical lifts should be used. According to the Physical Therapy Evaluation and Plan of Treatment dated (MONTH) 14, (YEAR), the resident was totally dependent with bed mobility and transfers and required maximum assistance. A nurses note dated (MONTH) 16, (YEAR), revealed the resident was a Hoyer lift for transfers and was totally dependent on two+ persons for assistance. Review of a psych progress note dated (MONTH) 22, (YEAR), revealed resident denies any feelings of anxiety and reports that she feels very stable on her current psychiatric medications, which included duloxetine (anti-depressant) and [MEDICATION NAME] (for [MEDICAL CONDITION]). The progress note also stated that staff report no agitation/anxiety symptoms and no aggression or bizarre behaviors since admission. According to a quarterly MDS (Minimum Data Set) assessment dated (MONTH) 25, (YEAR), the resident scored a 13 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. Per the MDS, the resident required extensive assistance of two persons with bed mobility, transfers, dressing and toilet use, and was totally dependent on two persons with transfers. The MDS also noted that the resident did not have any behaviors. A physical therapy note dated (MONTH) 4, (YEAR), revealed the resident started therapy and had needed 100% assistance, but now has improved to 20 % assistance. The note included that for bed mobility and sit to stand, the resident was a moderate assist of two persons with a front wheel walker. A nurses note dated (MONTH) 5, (YEAR) included the resident required extensive assistance of two staff members for transfers, secondary to generalized weakness and size, and utilizes a mechanical lift as needed. Review of the nurse's notes from (MONTH) 11, (YEAR) to (MONTH) 6, (YEAR), revealed no documentation that the resident experienced any fearfulness, any anxiety type behaviors or ADL decline. Review of clinical record revealed that resident #292 did not have any falls, since admission. A nurses note dated (MONTH) 6, (YEAR) revealed that a CNA (certified nursing assistant/staff #18) transferred the resident alone by herself from the bed to the wheelchair, with the help of a walker. While attempting to sit into the wheelchair, the resident slid to the floor on her knees. The note included that two staff members (CNA #18 and nurse #56) with the help of a sit/stand Hoyer lift assisted the resident from the floor to the wheelchair. The resident had no injuries except for a right hip old superficial blister, which had popped and a dressing was applied. A IDT review note dated (MONTH) 7, (YEAR), revealed a non-injury fall related to weakness during transfer and resident placed on alert charting. Review of the nurses progress notes from (MONTH) 7, (YEAR) through Discharge (September 27, (YEAR)) revealed the following: September 7: Resident did not want to get out of bed this shift and also refused therapy this a.m. September 8: Resident hitting CNA's during brief changes, refusing to help transfer self, demonstrates anxious behaviors when receiving ADL assistance and yelling from the room. September 9: Resident did not get out of bed this shift or the evening shift. September 10: Resident demonstrates anxious behaviors when receiving ADL assistance. Resident non-compliant with transfers and repositioning. Refusing care such as toileting, repositioning, getting out of bed and physical and occupational therapy. September 11 and 12: Resident demonstrates anxious behaviors when receiving ADL assistance; refusing care such as toileting, repositioning and getting out of bed. September 15: An incident note by the nurse included that around 9 p.m., the resident became afraid and scared that she was going to fall during a brief change. The resident remained upset and asked the nurse to call the doctor for something to calm the nerves. The nurse obtained an order for [REDACTED]. September 17: Resident demonstrates anxious behaviors when receiving ADL assistance, non-compliant with transfer and repositioning. Patient refusing care such as toileting, repositioning, getting out of bed and refusing physical and occupational therapy. September 18: Resident still refusing to get out of bed and non-compliant with most ADL's. Refusing PT/OT. Nurse Practitioner (NP) notified regarding resident's statements of anxiousness and fearful thoughts of falling out of bed. September 19: Resident requesting PRN [MEDICATION NAME] due to anxiousness, agitation and fear of falling out of bed. Demonstrates anxious behaviors when receiving ADL assistance and non-compliant with transfers and repositioning. Refusing care such as toileting, repositioning and getting out of bed. [MEDICATION NAME] given as needed. September 20: Resident refused to get out of bed this shift, refused to take a shower and multiple attempts made to encourage out of bed activities. The majority of all meals were served in her room per resident's request. September 21: Resident demonstrates anxious behaviors when receiving ADL assistance, non-compliant with transfers and repositioning. Refusing care such as toileting, repositioning and getting out of bed, [MEDICATION NAME] as needed. September 22: Demonstrates anxious behaviors when receiving ADL assistance, non-compliant with transfers and repositioning. Refusing care such as toileting, repositioning, getting out of bed and PT/OT. [MEDICATION NAME] given as needed.

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

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.

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F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) September 24: Resident is alert and oriented, remained in bed all day per her request. Non-compliant with ADL's and PT/OT. September 25: Resident refusing brief changes with CNA's. Went in and spoke with resident and offered [MEDICATION NAME], which previously had been effective with fear of falling during brief changes. The resident continued to refuse. The night shift note stated the resident also feels like she is going to fall when rolled from back to side. Non-compliant with most ADL's, PT and OT. (MONTH) 26: Resident alert and oriented x 2 confused and anxious. Resident feels like she is going to fall when rolled from back to side. Non-compliant with most ADL's, PT and OT. Review of the therapy treatment notes from (MONTH) 6, (YEAR) to Discharge (September 27, (YEAR)) revealed the following: September 6, 7 and 10: Resident refused multiple attempts to participate in therapy in the therapy room or in the room. September 11: Resident is a Hoyer, tolerated sitting in wheelchair for lunch. Refused to go to the gym. Resident making very minimal progress at this time. Resident requires motivation and encouragement to participate. Resident fearful of falling, resistive with staff with rolling and changing brief. Resident was reassured she is safe and was not going to fall. September 12: Resident refused therapy services, refused to get out of bed. September 17: Making very minimal progress at this time due to lack of participation and missed visits. Resident requesting pain medications and [MEDICATION NAME]. She stated that she would like to follow up with her psychiatrist, as she is fearful of falling when being changed and is afraid that she will fall out of bed. Resisting care with CNA's. September 18: Straight leg raising was attempted during therapy but unable to complete. September 19, 20, 21 and 22: Resident making minimal progress, unmotivated and has fear of falling. Refused multiple attempts to participate in therapy and getting out of bed. September 24: Therapy discharge summary included resident has steadily declined. Refuses to get out of bed due to lack of motivation, effort. Resident is being discharged at this time from therapy. Review of the resident's care plans dated (MONTH) 17, (YEAR), revealed the resident uses anti-anxiety medication ([MEDICATION NAME]) related to an anxiety disorder. A goal included the resident will have decreased episodes of signs and symptoms of anxiety. Interventions included to give anti-anxiety medications as ordered, monitor side effects and track target behaviors of statements of anxiousness. A psych eval progress note dated (MONTH) 19, (YEAR) revealed staff reports that last week resident had a fall and it appears to have resulted in worsening depression and anxiety. The resident has anxiety symptoms of excessive worry/anxiety and being fearful. The recommendation was to continue [MEDICATION NAME] 0.5 mg every 12 hrs as needed for anxiety, as evidence by agitation and fearfulness. Further review of the clinical record revealed the resident was discharged on (MONTH) 27, (YEAR). The facility was unable to provide any evidence that the incident regarding a fall due to an unsafe transfer, which resulted in the resident experiencing psychological distress and overall decline was identified as neglect. In addition, there was no evidence that the incident was thoroughly investigated. An interview with a CNA (staff #18) was conducted on (MONTH) 26, 2019 at 11:47 a.m. She stated when the resident fell , she was transferring the resident with the help of a gait belt and walker. She said the resident slid out of the wheelchair and sat straight down on her knees. Staff #18 stated that she was told by therapy the day before that the resident was going to be an extensive assist of one person for transfers, instead of two. An interview was conducted on (MONTH) 26, 2019 at 12:05 p.m. with a licensed practical nurse (LPN/staff #56), who worked the day shift on (MONTH) 6, (YEAR) when the resident fell . She stated that she was going into the resident's room to give her medications and when she entered the room, the resident was on her knees on the floor in front of the wheelchair. She said the CNA was in the room and had tried to transfer the resident. Staff #56 stated that she asks therapy every day for any changes with the resident's ability and type of assistance needed with transfers, and then documents it in a progress note. She stated if she documented the resident needs two person extensive assistance, it means that she clarified this with therapy, prior to documenting it. An interview with a physical therapy assistant (PTA/staff #58) was conducted on (MONTH) 26, 2019 at 12:58 p.m. At this time, the therapy notes were reviewed with staff #58, who stated the resident was a two person transfer at the time of the fall. She said that since the resident was transferred from the bed to a standing position, it would require two persons. She stated the resident was making good progress, until the fall on (MONTH) 6, (YEAR). An interview with a registered nurse (RN/staff #83) was conducted on (MONTH) 26, 2019 at 4:10 p.m. Staff #83 stated that she usually works the night shift and that the resident was a two person Hoyer lift for transfers at all times. An interview with the Assistant Director of Nursing (ADON/staff #36) and the Executive Director(ED/staff #10) was conducted on (MONTH) 28, 2019 at 8:52 a.m. Staff #36 stated that staff should care plan the number of staff assistance which is needed for transfers in the care plan within 24 hours of admit, because the care plan also transfers to the kardex where the CNA's look to find out how much help a resident needs with transfers. She stated that it would be neglect if staff were not following the care plan or therapy orders for transfers. Staff #36 said she would expect the CNA's to follow what therapy recommends for transfers. She stated if therapy makes any changes in the transfer status, she expects them to document it in their notes. At this time, the fall documentation was reviewed with staff #36. She stated that during an IDT meeting (which included the Director of Nusing (DON), ADON, the Care Coordinator and therapy), it was not identified that the fall was an unsafe transfer. Staff #36 said that since they did not identify the incident as neglect, they did not report or investigate the incident. Staff #10 stated that he remembers the resident and that after the fall, the resident was scared to leave the room or get out of bed. According to the Lifting Machine policy, the use of a mechanical lift for resident transfers will be conducted with the assistance of at least two nursing assistants to safely move a resident. Types of mechanical lifts include sit to stand lifts. Regarding an allegation of abuse for resident #292: Review of a facility's investigation report revealed that on (MONTH) 27, (YEAR) on the night shift between 3-6 a.m., a CNA (staff #85) witnessed another CNA (staff #86) telling resident #292 to shut up and threaten to drop the resident if she did not stop swinging her arms around, while changing the resident's brief. Staff #85 reported the resident was reaching her arms out, because she was afraid of falling and wanted help. Staff #85 reported that staff #86 told the resident that if she hits her, I will drop you. The investigation included a written interview with staff #86 who said that on (MONTH) 27, (YEAR), she yelled at resident #292 because the resident was afraid of falling and she needed to calm down. Staff #86 stated that she told the resident that she might drop her if she did not calm down or if she hit her. The investigation report also included an interview with resident #292's roommate who stated that on (MONTH) 27, (YEAR), she heard resident #292 yelling because she was scared that she was going to fall out of bed. The roommate stated that she heard one of the staff tell the resident to shut-up or be quiet. The roommate stated that she was upset and did not like what was happening. -Resident #16 was admitted to the facility on (MONTH) 6, (YEAR), with [DIAGNOSES REDACTED]. A review of the quarterly MDS assessment dated (MONTH) 14, (YEAR), revealed a BIMS (Brief Interview for Mental Status) score of 14, which indicated the resident had intact cognition. Review of the facility's investigation report revealed that on (MONTH) 27, (YEAR) during the night shift between 3:00 a.m. and 6:00 a.m., a CNA (staff #85) witnessed another CNA (staff #86) swearing and handling resident #16 rough, when changing the resident's brief. The report included that staff #85 had asked staff #86 to help her change the resident's brief. Staff #85 reported that while changing the resident's brief, staff #86 said that she did not know why the resident waits so long to pee, while grabbing and yanking the resident towards her. Per the report, staff #86 also hurriedly turned the resident on her side, so she could change the resident's sheets. Staff #85 reported that she thought staff #86 intended to be mean and that staff #86 had been frustrated all night. The resident reported that she was awakened by staff and that staff #86 was saying damn it or God damn it because her bed was wet. The resident said that staff #86 shoved her hard to the side while changing her sheets and that she knew staff #86 was mad, because her bed sheets were wet. The investigation also included a written interview with staff #86 who stated that she was swearing while in the resident's room, because she was frustrated. Staff #86 reported that she said crap and may have said sh Staff #86 said that she could see how the resident may have thought that she was swearing at her and that she did not mean to shove and push the resident onto her side and back at medium speed, while changing the resident's sheets.

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F 0600 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) An interview was conducted with resident #16 on (MONTH) 27, 2019 at 2:29 p.m., who stated that staff #86 came into her room on (MONTH) 27, (YEAR) and shoved her so hard that she hit the bedrail. The resident stated that she was not hurt, but she was humiliated. She said staff #86 was angry and swearing because her bed was wet. She also stated that another CNA (staff #85) was present, but did not say anything. An interview was conducted on (MONTH) 28, 2019 at 8:52 a.m., with the Assistant Director of Nursing (ADON/staff #36) and the Executive Director (ED/staff #10). The ADON said that their policy includes that abuse can be physical, mental, verbal or emotional. -Resident #244 was admitted on (MONTH) 24, (YEAR) and readmitted on (MONTH) 31, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 4, (YEAR). The admission MDS assessment dated (MONTH) 31, (YEAR) revealed a BIMS score of 3, which indicated the resident had severe impaired cognition. According to the resident's care plans, the resident did not exhibit any physical or verbal aggression towards others. Review of the facility's investigation report revealed that on (MONTH) 27, (YEAR) on the night shift between 3 a.m. - 6 a.m., staff #85 asked staff #86 to help her change resident #244's brief. Staff #85 was having difficulty because resident #244 pulled her pants up and said that she was cold. Staff #86 told staff #85 that she was going to show her a trick. Staff #86 then proceeded to pull the resident's pants down, tore open the brief, forced the resident to roll over, and pried the resident's legs apart. Staff #85 stated that she felt that staff #86 forced the resident to roll over. Staff #85 reported that staff #86 told the resident to open her legs and then told staff #85, I kind of forced her to open her legs. The resident then said that she wanted to be left alone. Staff #85 said she believed that staff #86 was trying to be mean, had been frustrated all night and forced resident #244 to open her legs. The investigation also included an interview with resident #244, but she was unable to remember anything that occurred on (MONTH) 27. -Resident #3 was readmitted to the facility on (MONTH) 1, (YEAR), with [DIAGNOSES REDACTED]. A review of the quarterly MDS assessment dated (MONTH) 18, (YEAR), revealed a BIMS score of 6, which indicated the resident had severe cognitive impairment. Review of the facility's investigation report revealed that on (MONTH) 27, (YEAR) on the night shift between 3:00 a.m. and 6:00 a.m., staff #85 reported that she and staff #86 woke resident #3 up to change his brief. Staff #85 said the resident was having trouble standing up, so staff #86 told the resident Fine, you don't get changed tonight and left the room. The investigation report included a written interview with staff #86, who reported that she yelled at the resident to get him to stand up. She stated that she was frustrated, because the resident was not helping her change his brief. The report included that staff #86 stated that she cannot control the volume or tone of her voice. Further review of the investigative findings regarding the allegations of abuse for resident #3, #16, #244 and #292, revealed they all occurred on the night shift on (MONTH) 27, (YEAR) sometime between 3 a.m. - 6 a.m. and involved staff #86. The documentation also included the following: Staff #86 was physically more forceful than needed when providing care, raised her voice and used profanity. Staff #86 was perceived by staff and residents as being angry and frustrated. Staff #86 was involuntary terminated. An interview was conducted on (MONTH) 28, 2019 at 8:52 a.m. with the Assistant Director of Nursing (ADON/staff #36) and the Executive Director (ED/staff #10). Staff #36 said that their policy includes that abuse can be physical, mental, verbal or emotional. She said that during new hire orientation, staff receive abuse training and that their first priority is to protect the residents. Staff #10 stated that the incidents of suspected abuse (for resident #3, #16, #244 and #292) occurred on the night shift on (MONTH) 27, (YEAR) between 3 a.m. - 6 a.m. He said abuse training is provided throughout the year and they have had several trainings on abuse in the past 6 months. Review of the Resident Rights policy revised (MONTH) (YEAR), revealed that employees shall treat all residents with kindness, respect and dignity. Residents have the right to be free from abuse and neglect. Review of the facility's Abuse policy dated (MONTH) (YEAR) revealed the facility strives to prevent the abuse of all residents. The objective is to provide a safe haven for residents through preventative measures which protect residents right to be free from abuse and neglect. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual of goods or services that are necessary to maintain physical, mental and psychosocial well-being. Instances of abuse cause physical harm, pain or mental anguish. Abuse includes verbal abuse, sexual abuse, physical abuse, mental abuse and neglect. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. If abuse/neglect is witnessed or suspected, the resident's safety will immediately be secured. Prompt reporting and investigation will be utilized to identify the validity of findings and reasonable measures will be implemented to deter further incidents of abuse/neglect.
F 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record reviews, staff interviews, facility documentation and policy review, the facility failed to ensure two sampled residents (#'s 33 and 16) were free from misappropriation of property. The deficient practice could result in other residents' narcotics being misappropriated. Findings include: -Resident #33 was admitted to the facility on (MONTH) 17, (YEAR) with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The Medication Administration Record [REDACTED]. Review of the controlled substance record for (MONTH) (YEAR) revealed 20 tablets of [MEDICATION NAME] 5 mg was delivered to the facility. The record also included that on (MONTH) 13, (YEAR), 16 tablets had been administered and 4 tablets were left.- Resident #16 was admitted to the facility on (MONTH) 6, (YEAR) with a [DIAGNOSES REDACTED]. The physician orders [REDACTED]. The MAR for (MONTH) (YEAR) included the above orders and the documentation showed the resident received [MEDICATION NAME] on multiple days. Review of the controlled substance record dated (MONTH) (YEAR) revealed the facility had received 30 tablets of [MEDICATION NAME] 2.5 mg from the pharmacy. The record also revealed that on (MONTH) 13, (YEAR), 17 tablets had been administered and 13 tablets were left. Review of the facility's investigation report with a reference date of (MONTH) 14, (YEAR), revealed a staff member discovered that one [MEDICATION NAME] blister packet for resident #33 was missing and one blister packet for resident #16 was missing. The report included that between the two residents, there were a total of 17 [MEDICATION NAME] tablets which were missing. The report also included a Registered Nurse (RN/staff #84) was identified as a suspect and eventually confessed to taking the 17 [MEDICATION NAME] tablets. The investigation report included a written statement from staff #20 dated (MONTH) 14, (YEAR). The RN had found the [MEDICATION NAME] controlled substance records for residents #33 and #16 hidden under the narcotic book which was on top of the medication cart. The [MEDICATION NAME] 5 mg controlled substance record for resident #33 revealed there should be 13 tablets left in the blister packet. The [MEDICATION NAME] 2.5 mg controlled substance record for resident #16 revealed there should be 4 tablets left in the blister packet. The statement further included that the [MEDICATION NAME] blister packets for residents #33 and #16 were not in the medication cart. Review of the personnel record for staff #84 revealed staff #84 was terminated on (MONTH) 17, (YEAR). The file also contained evidence that staff #85 had been provided training and education on abuse and misappropriation of personal property. Attempts to contact staff #84 via telephone were unsuccessful. An interview was conducted with staff #20 on (MONTH) 26, 2019 at 10:21 a.m. Staff #20 stated that he found the controlled substance records for residents #33 and #16 hidden in a binder on top of the medication cart. Staff #20 also stated that he was not able to find the [MEDICATION NAME] blister packets for the residents in the medication cart. He stated that he notified the Director of Nursing (DON/staff #31) and an investigation was initiated. During an interview conducted with staff #31 on (MONTH) 26, 2019 at 10:50 a.m., the DON stated that the missing narcotics

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F 0602 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) were considered misappropriation of personal property. Staff #31 stated that staff #84 stole resident #33 and resident #16 [MEDICATION NAME]. The facility's policy regarding Abuse revealed the facility strives to prevent abuse of all residents. Per the policy, abuse includes misappropriation of personal property. The objective is to provide a safe haven for the residents through preventative measures that protect every resident's right to be free from abuse.
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record reviews, staff interviews, facility documentation and policy and procedures, the facility failed to implement their abuse policy, by failing to immediately report allegations of abuse to the administrator/designee, by failing to report the allegations of abuse to the State Agency within two hours, and by failing to protect residents from the potential for further abuse for 4 of 5 sampled residents (#3, #16, #244 and #292). The facility also failed to identify an incident of neglect for one resident (#292), failed to report the incident of neglect to the State Agency, failed to conduct a thorough investigation and failed to protect residents from the potential for further neglect. Findings include: -Resident #292 was admitted to the facility on (MONTH) 11, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 27, (YEAR). Regarding an incident of neglect: Review of the baseline care plan-admission evaluation dated (MONTH) 11, (YEAR) under the section for ADL's (activities of daily living), revealed that resident #292 was alert and oriented x 4 and was totally dependent on two staff with transfers. The documentation included the resident had severe impairment with movement to bilateral legs and hips. Review of the ADL care plan dated (MONTH) 13, (YEAR), revealed the resident had an ADL self-care performance deficit, related to deconditioning. One of the interventions included that staff participation was required for transfers. However, the care plan did not specify how many staff were required for transfers or if mechanical lifts should be used. According to the Physical Therapy Evaluation and Plan of Treatment dated (MONTH) 14, (YEAR), the resident was totally dependent with bed mobility and transfers, and required maximum assistance. A nurses note dated (MONTH) 16, (YEAR), revealed the resident was a Hoyer lift for transfers and was totally dependent on two+ persons for assistance. According to a quarterly MDS (Minimum Data Set) assessment dated (MONTH) 25, (YEAR), the resident scored a 13 on the BIMS, indicating intact cognition. Per the MDS, the resident required extensive assistance of two persons with bed mobility, transfers, dressing and toilet use, and was totally dependent on two persons with transfers. A physical therapy note dated (MONTH) 4, (YEAR), revealed the resident started therapy and had needed 100% assistance, but now has improved to 20 % assistance. The note included that for bed mobility and sit to stand, the resident was a moderate assist of two persons with a front wheel walker. A nurses note dated (MONTH) 5, (YEAR) included the resident required extensive assistance of two staff members for transfers, secondary to generalized weakness and size, and utilizes a mechanical lift as needed. Review of clinical record revealed that resident #292 did not have any falls, since admission. A nurses note dated (MONTH) 6, (YEAR) revealed that a CNA (certified nursing assistant/staff #18) transferred the resident alone by herself from the bed to the wheelchair, with the help of a walker. While attempting to sit into the wheelchair, the resident slid to the floor on her knees. The note included that two staff members (CNA #18 and nurse #56) with the help of a sit/stand Hoyer lift assisted the resident from the floor to the wheelchair. The resident had no injuries except for a right hip old superficial blister, which had popped and a dressing was applied. Review of the IDT review note dated (MONTH) 7, (YEAR), revealed a non-injury fall related to weakness during transfer and resident placed on alert charting. The facility was unable to provide any evidence that the incident regarding the fall was identified as neglect, that the incident was investigated or reported to the State Agency within two hours. There was also no evidence that staff #18 was removed from providing direct care to residents, pending an investigation. An interview was conducted on (MONTH) 26, 2019 at 12:05 p.m. with a licensed practical nurse (LPN/staff #56), who worked the day shift on (MONTH) 6, (YEAR) when the resident fell . She stated that she was going into the resident's room to give her medications and when she entered the room, the resident was on her knees on the floor in front of the wheelchair. She said the CNA was in the room and had tried to transfer the resident. Staff #56 stated that she asks therapy every day for any changes with the resident's ability and type of assistance needed with transfers, and then documents it in a progress note. She stated if she documented the resident needs two person extensive assistance, it means that she clarified this with therapy, prior to documenting it. An interview with a physical therapy assistant (PTA/staff #58) was conducted on (MONTH) 26, 2019 at 12:58 p.m. At this time, the therapy notes were reviewed with staff #58, who stated the resident was a two person transfer at the time of the fall. She said that since the resident was transferred from the bed to a standing position, it would require two persons. During an interview with a RN (staff #83) conducted on (MONTH) 26, 2019 at 4:10 p.m., the RN said that she usually works the night shift and that the resident was a two person Hoyer lift for transfers at all times. An interview was conducted with the Assistant Director of Nursing (ADON/staff #36) and the Executive Director (ED/staff #10) on (MONTH) 28, 2019 at 8:52 a.m. Staff #36 stated that staff should care plan the number of staff assistance which is needed for transfers in the care plan within 24 hours of admit, because the care plan also transfers to the kardex where the CNA's look to find out how much help a resident needs with transfers. She stated that it would be neglect if staff were not following the care plan or therapy orders for transfers. Staff #36 said she would expect the CNA's to follow what therapy recommends for transfers. She stated if therapy makes any changes in the transfer status, she expects them to document it in their notes. At this time, the fall documentation was reviewed with staff #36. She stated that during an IDT meeting (which included the Director of Nusing (DON), ADON, the Care Coordinator and therapy), it was not identified that the fall was an unsafe transfer. Staff #36 said that since they did not identify the incident as neglect, they did not report the incident to the State Agency or investigate the incident. Regarding an allegation of abuse for resident #292: Review of a facility's investigation report revealed that on (MONTH) 27, (YEAR) on the night shift between 3-6 a.m., a CNA (staff #85) witnessed another CNA (staff #86) telling resident #292 to shut up and threaten to drop the resident if she did not stop swinging her arms around, while changing the resident's brief. Staff #85 reported the resident was reaching her arms out, because she was afraid of falling and wanted help. Staff #85 reported that staff #86 told the resident that if she hits her, I will drop you. The investigation included a written interview with staff #86, who said that on (MONTH) 27, (YEAR), she yelled at resident #292 because the resident was afraid of falling and she needed to calm down. Staff #86 stated that she told the resident that she might drop her if she did not calm down or if she hit her. The investigation report also included an interview with resident #292's roommate, who stated that on (MONTH) 27, (YEAR) she heard resident #292 yelling, because she was scared that she was going to fall out of bed. The roommate stated that she heard one of the staff tell the resident to shut-up or be quiet. The roommate stated that she was upset and did not like what was happening. Further review of the investigation report revealed that the allegation of abuse was not reported immediately to the administrator/designee, and that the State Agency was not notified of the allegation of abuse until (MONTH) 27, (YEAR) at 8:54 a.m. In addition, there was no documentation that staff #85 was immediately removed from providing care to residents, pending the investigation. -Resident #16 was admitted to the facility on (MONTH) 6, (YEAR), with [DIAGNOSES REDACTED]. A review of the quarterly MDS assessment dated (MONTH) 14, (YEAR), revealed a BIMS score of 14, which indicated the resident had intact cognition. Review of the facility's investigation report revealed that on (MONTH) 27, (YEAR) during the night shift between 3:00 a.m. and 6:00 a.m., a CNA (staff #85) witnessed another CNA (staff #86) swearing and handling resident #16 rough, when changing the resident's brief. The report included that staff #85 had asked staff #86 to help her change the resident's brief. Staff #85 reported that while changing the resident's brief, staff #86 said that she did not know why the resident waits so long

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	035118	A. BUILDING _____ B. WING _____	03/28/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF CAMP VERDE	86 WEST SALT MINE ROAD CAMP VERDE, AZ 86322

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) to pee, while grabbing and yanking the resident towards her. Per the report, staff #86 also hurriedly turned the resident on her side, so she could change the resident's sheets. Staff #85 reported that she thought staff #86 intended to be mean and that staff #86 had been frustrated all night. The resident reported that she was awakened by staff and that staff #86 was saying damn it or God damn it because her bed was wet. The resident said that staff #86 shoved her hard to the side while changing her sheets and that she knew staff #86 was mad, because her bed sheets were wet. The investigation also included a written interview with staff #86 who stated that she was swearing while in the resident's room, because she was frustrated. Staff #86 reported that she said crap and may have said sh Staff #86 said that she could see how the resident may have thought that she was swearing at her and that she did not mean to shove and push the resident onto her side and back at medium speed, while changing the resident's sheets. Further review of the investigation report revealed there was no evidence that the Administrator/designee was immediately notified at the time of the incident or that staff #85 was immediately removed from providing care to residents, pending the investigation. Further review revealed that the State Agency was not notified of the allegation of abuse until (MONTH) 27, (YEAR) at 8:54 a.m., which was over the two hour timeframe for reporting. An interview was conducted with resident #16 on (MONTH) 27, 2019 at 2:29 p.m., who stated that staff #86 came into her room on (MONTH) 27, (YEAR) and shoved her so hard that she hit the bedrail. The resident stated that she was not hurt, but she was humiliated. She said staff #86 was angry and swearing because her bed was wet. She also stated that another CNA (staff #85) was present, but did not say anything. -Resident #244 was admitted on (MONTH) 24, (YEAR) and readmitted on (MONTH) 31, (YEAR) with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 4, (YEAR). The admission MDS assessment dated (MONTH) 31, (YEAR) revealed a BIMS score of 3, which indicated the resident had severe impaired cognition. Review of the facility's investigation report revealed that on (MONTH) 27, (YEAR) on the night shift between 3 a.m. - 6 a.m., staff #85 asked staff #86 to help her change resident #244's brief. Staff #85 was having difficulty because resident #244 pulled her pants up and said that she was cold. Staff #86 told staff #85 that she was going to show her a trick. Staff #86 then proceeded to pull the resident's pants down, tore open the brief, forced the resident to roll over, and pried the resident's legs apart. Staff #85 stated that she felt that staff #86 forced the resident to roll over. Staff #85 reported that staff #86 told the resident to open her legs and then told staff #85, I kind of forced her to open her legs. The resident then said that she wanted to be left alone. Staff #85 said she believed that staff #86 was trying to be mean, had been frustrated all night and forced resident #244 to open her legs. Further review of the investigation report revealed there was no evidence that the Administrator/designee was immediately notified at the time of the incident or that staff #85 was immediately removed from providing care to residents, pending the investigation. Further review revealed that the State Agency was not notified of the allegation of abuse until (MONTH) 27, (YEAR) at 8:54 a.m., which was over the two hour timeframe for reporting. -Resident #3 was readmitted to the facility on (MONTH) 1, (YEAR), with [DIAGNOSES REDACTED]. A review of the quarterly MDS assessment dated (MONTH) 18, (YEAR), revealed a BIMS score of 6, which indicated the resident had severe cognitive impairment. Review of the facility's investigation report revealed that on (MONTH) 27, (YEAR) on the night shift between 3:00 a.m. and 6:00 a.m., staff #85 reported that she and staff #86 woke resident #3 up to change his brief. Staff #85 said the resident was having trouble standing up, so staff #86 told the resident Fine, you don't get changed tonight and left the room. The investigation report included a written interview with staff #86, who reported that she yelled at the resident to get him to stand up. She stated that she was frustrated, because the resident was not helping her change his brief. The report included that staff #86 stated that she cannot control the volume or tone of her voice. Further review of the investigative findings regarding the allegations of abuse for resident #3, #16, #244 and #292, revealed they all occurred on the night shift on (MONTH) 27, (YEAR) sometime between 3 a.m. - 6 a.m. and involved staff #86. The documentation also included the following: Staff #86 was physically more forceful than needed when providing care, raised her voice and used profanity. Staff #86 was perceived by staff and residents as being angry and frustrated. Staff #86 was involuntary terminated. Continued review of the investigation report revealed there was no evidence that the Administrator/designee was immediately notified at the time of the incident or that staff #85 was immediately removed from providing care to residents, pending the investigation. Further review revealed that the State Agency was not notified of the allegation of abuse until (MONTH) 27, (YEAR) at 8:54 a.m., which was over the two hour timeframe for reporting. An interview was conducted on (MONTH) 28, 2019 at 8:52 a.m. with the Assistant Director of Nursing (ADON/staff #36) and the Executive Director (ED/staff #10). Staff #36 said that their policy includes that abuse can be physical, mental, verbal or emotional. She said that during new hire orientation, staff receive abuse training and that their first priority is to protect the residents. Staff #10 stated that the incidents of suspected abuse (for resident #3, #16, #244 and #292) occurred on the night shift on (MONTH) 27, (YEAR) between 3 a.m. - 6 a.m., and the alleged perpetrator (staff #86) worked until the end of her shift, which ended at 6:00 a.m. He stated that staff #85 reported the allegations of abuse to the day shift CNA's and that he was notified of the allegations around 8:00 a.m. on (MONTH) 27. He said that staff #85 was formally disciplined and re-educated for not reporting the suspected abuse immediately. He said the regulation requires the facility to call and report abuse within two hours from the point of notification and defined notification as the time the suspected abuse happened. He said abuse training is provided throughout the year and they have had several trainings on abuse in the past 6 months. Staff #36 stated that all staff have been told to call the ED, the DON or ADON right away if they can't find the charge nurse to report the abuse. Staff #36 said they have told staff to call until they get a hold of somebody. She said that staff who witness an allegation of abuse is expected to ask the alleged perpetrator to leave the building. Review of the facility's abuse policy dated (YEAR), revealed that the facility strives to prevent the abuse of all residents. The objective is to provide a safe haven for residents through preventative measures which protect residents right to be free from abuse and neglect. If abuse/neglect is witnessed or suspected, the resident's safety will immediately be secured. If staff is suspected of being the abuser, they will be suspended until the investigation is complete. The policy also included that if abuse is witnessed or suspected, the Executive Director will be notified, and the ED and the witness who is reporting will notify the State Survey Agency in accordance with timeframes and standards required by the State Agency. Prompt reporting and investigation will be utilized to identify the validity of findings and reasonable measures will be implemented to deter further incidents of abuse. The policy also included the ED will begin an investigation immediately and will complete the investigation within 5 days using the abuse investigation packet. A minimum of 3 residents will be interviewed in order to determine if there is a trend. Staff members will document their own statements and sign and date them. The policy included that all abuse investigation information will be documented and kept in an abuse investigation binder.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record reviews, staff interviews, facility documentation and policy and procedures, the facility failed to immediately report allegations of abuse to the administrator/designee and failed to report the allegations of abuse to the State Agency within two hours for 4 of 5 sampled residents (#3, #16, #244 and #292). The facility also failed to report an incident of neglect within 2 hours to the State Agency involving one resident (#292). A delay in reporting resulted in residents being subjected to further abuse and a delay in initiating the investigative process. Findings include: -Resident #292 was admitted to the facility on (MONTH) 11, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 27, (YEAR). Regarding an incident of neglect: Review of the baseline care plan-admission evaluation dated (MONTH) 11, (YEAR) under the section for ADL's (activities of daily living), revealed that resident #292 was alert and oriented x 4 and was totally dependent on two staff with

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) transfers. The documentation included the resident had severe impairment with movement to bilateral legs and hips. Review of the ADL care plan dated (MONTH) 13, (YEAR), revealed the resident had an ADL self-care performance deficit, related to deconditioning. One of the interventions included that staff participation was required for transfers. However, the care plan did not specify how many staff were required for transfers or if mechanical lifts should be used. According to the Physical Therapy Evaluation and Plan of Treatment dated (MONTH) 14, (YEAR), the resident was totally dependent with bed mobility and transfers, and required maximum assistance. A nurses note dated (MONTH) 16, (YEAR), revealed the resident was a Hoyer lift for transfers and was totally dependent on two+ persons for assistance. According to a quarterly MDS (Minimum Data Set) assessment dated (MONTH) 25, (YEAR), the resident scored a 13 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. Per the MDS, the resident required extensive assistance of two persons with bed mobility, transfers, dressing and toilet use, and was totally dependent on two persons with transfers. A physical therapy note dated (MONTH) 4, (YEAR), revealed the resident started therapy and had needed 100% assistance, but now has improved to 20 % assistance. The note included that for bed mobility and sit to stand, the resident was a moderate assist of two persons with a front wheel walker. A nurses note dated (MONTH) 5, (YEAR) included the resident required extensive assistance of two staff members for transfers, secondary to generalized weakness and size, and utilizes a mechanical lift as needed. Review of clinical record revealed that resident #292 did not have any falls, since admission. A nurses note dated (MONTH) 6, (YEAR) revealed that a CNA (certified nursing assistant/staff #18) transferred the resident alone by herself from the bed to the wheelchair, with the help of a walker. While attempting to sit into the wheelchair, the resident slid to the floor on her knees. The note included that two staff members (CNA #18 and nurse #56) with the help of a sit/stand Hoyer lift assisted the resident from the floor to the wheelchair. The resident had no injuries except for a right hip old superficial blister, which had popped and a dressing was applied. Review of the IDT review note dated (MONTH) 7, (YEAR), revealed a non-injury fall related to weakness during transfer and resident placed on alert charting. Review of the State Agency data base revealed the allegation of neglect was not reported. An interview was conducted on (MONTH) 26, 2019 at 12:05 p.m. with a licensed practical nurse (LPN/staff #56), who worked the day shift on (MONTH) 6, (YEAR) when the resident fell . She stated that she was going into the resident's room to give her medications and when she entered the room, the resident was on her knees on the floor in front of the wheelchair. She said the CNA was in the room and had tried to transfer the resident. Staff #56 stated that she asks therapy every day for any changes with the resident's ability and type of assistance needed with transfers, and then documents it in a progress note. She stated if she documented the resident needs two person extensive assistance, it means that she clarified this with therapy, prior to documenting it. An interview with a physical therapy assistant (PTA/staff #58) was conducted on (MONTH) 26, 2019 at 12:58 p.m. At this time, the therapy notes were reviewed with staff #58, who stated the resident was a two person transfer at the time of the fall. She said that since the resident was transferred from the bed to a standing position, it would require two persons. She stated the resident was making good progress, until the fall on (MONTH) 6, (YEAR). An interview with a registered nurse (RN/staff #83) was conducted on (MONTH) 26, 2019 at 4:10 p.m. Staff #83 stated that she usually works the night shift and that the resident was a two person Hoyer lift for transfers at all times. An interview with the Assistant Director of Nursing (ADON/staff #36) and the Administrator (ED/staff #10) was conducted on (MONTH) 28, 2019 at 8:52 a.m. Staff #36 stated that staff should care plan the number of staff assistance which is needed for transfers in the care plan within 24 hours of admit, because the care plan also transfers to the kardex where the CNA's look to find out how much help a resident needs with transfers. She stated that it would be neglect if staff were not following the care plan or therapy orders for transfers. Staff #36 said that she would expect the CNA's to follow what therapy recommends for transfers. She further stated that she expects staff to report abuse or suspicion of abuse to the Executive Director, Director of Nursing or the ADON immediately. She stated that they have two hours to report allegations of abuse to the officials. She stated that they did not identify the transfer for resident #292 as unsafe or as neglect/abuse, therefore they did not report the incident to the State Agency. Regarding an abuse allegation for resident #292: Review of a facility's investigation report revealed that on (MONTH) 27, (YEAR) on the night shift between 3 a.m.- 6 a.m., CNA (staff #85) witnessed another CNA (staff #86) telling resident #292 to shut up and threaten to drop the resident if she did not stop swinging her arms around, while changing the resident's brief. Staff #85 reported the resident was reaching her arms out, because she was afraid of falling and wanted help. Staff #85 reported that staff #86 told the resident that if she hits her, I will drop you. The investigation included a written interview with staff #86, who said that on (MONTH) 27, (YEAR) she yelled at resident #292, because the resident was afraid of falling and she needed to calm down. Staff #86 stated that she told the resident that she might drop her if she did not calm down or if she hit her. The investigation report also included an interview with resident #292's roommate who stated that on (MONTH) 27, (YEAR) she heard resident #292 yelling, because she was scared that she was going to fall out of bed. The roommate stated that she heard one of the staff tell the resident to shut-up or be quiet. The roommate stated that she was upset and did not like what was happening. Further review of the investigation report revealed that the allegation of abuse was not reported immediately to the administrator/designee, and that the State Agency was not notified of the allegation of abuse until (MONTH) 27, (YEAR) at 8:54 a.m., which is over the two hour timeframe for reporting. -Resident #16 was admitted to the facility on (MONTH) 6, (YEAR), with [DIAGNOSES REDACTED]. Review of the facility's investigation report revealed that on (MONTH) 27, (YEAR) during the night shift between 3:00 a.m. and 6:00 a.m., a CNA (staff #85) witnessed another CNA (staff #86) swearing and handling resident #16 rough, when changing the resident's brief. The report included that staff #85 had asked staff #86 to help her change the resident's brief. Staff #85 reported that while changing the resident's brief, staff #86 said that she did not know why the resident waits so long to pee, while grabbing and yanking the resident towards her. Per the report, staff #86 also hurriedly turned the resident on her side, so she could change the resident's sheets. Staff #85 reported that she thought staff #86 intended to be mean and that staff #86 had been frustrated all night. The resident reported that she was awakened by staff and that staff #86 was saying damn it or God damn it because her bed was wet. The resident said that staff #86 shoved her hard to the side while changing her sheets and that she knew staff #86 was mad, because her bed sheets were wet. The investigation also included a written interview with staff #86 who stated that she was swearing while in the resident's room, because she was frustrated. Staff #86 reported that she said crap and may have said sh Staff #86 said that she could see how the resident may have thought that she was swearing at her and that she did not mean to shove and push the resident onto her side and back at medium speed, while changing the resident's sheets. An interview was conducted with resident #16 on (MONTH) 27, 2019 at 2:29 p.m., who stated that staff #86 came into her room on (MONTH) 27, (YEAR) and shoved her so hard that she hit the bedrail. The resident stated that she was not hurt, but she was humiliated. She said staff #86 was angry and swearing because her bed was wet. She also stated that another CNA (staff #85) was present, but did not say anything. Further review of the investigation report revealed that the allegation of abuse was not reported immediately to the administrator/designee, and that the State Agency was not notified of the allegation of abuse until (MONTH) 27, (YEAR) at 8:54 a.m., which is over the two hour timeframe for reporting. -Resident #244 was admitted on (MONTH) 24, (YEAR) and readmitted on (MONTH) 31, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 4, (YEAR). Review of the facility's investigation report revealed that on (MONTH) 27, (YEAR) on the night shift between 3 a.m.- 6:00 a.m., staff #85 asked staff #86 to help her change resident #244's brief. Staff #85 was having difficulty because resident #244 pulled her pants up as she was cold. Staff #86 told staff #85 that she was going to show her a trick. Staff #86 then proceeded to pull the resident's pants down, tore open the brief, forced the resident to roll over, and pried the resident's legs apart. Staff #85 stated that she felt that staff #86 forced the resident to roll over. Staff #85 reported that staff #86 told the resident to open her legs and then told staff #85, I kind of forced her to open her legs. The resident then said that she wanted to be left alone. Staff #85 said she believed that staff #86 was trying to be mean, had

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) been frustrated all night and forced resident #244 to open her legs. Further review of the investigation report revealed that the allegation of abuse was not reported immediately to the administrator/designee, and that the State Agency was not notified of the allegation of abuse until (MONTH) 27, (YEAR) at 8:54 a.m., which is over the two hour timeframe for reporting. -Resident #3 was readmitted to the facility on (MONTH) 1, (YEAR), with [DIAGNOSES REDACTED]. Review of the facility's investigation report revealed that on (MONTH) 27, (YEAR) on the night shift between 3:00 a.m. and 6:00 a.m., staff #85 reported that she and staff #86 woke resident #3 up to change his brief. Staff #85 said the resident was having trouble standing up, so staff #86 told the resident Fine, you don't get changed tonight and left the room. The investigation report included a written interview with staff #86, who reported that she yelled at the resident to get him to stand up. She stated that she was frustrated, because the resident was not helping her change his brief. The report included that staff #86 stated that she cannot control the volume or tone of her voice. Further review of the investigation report revealed that the allegation of abuse was not reported immediately to the administrator/designee, and that the State Agency was not notified of the allegation of abuse until (MONTH) 27, (YEAR) at 8:54 a.m. Continued review of the investigative findings regarding the allegations of abuse for resident #3, #16, #244 and #292, revealed they all occurred on the night shift on (MONTH) 27, (YEAR) sometime between 3 a.m. - 6 a.m. and involved staff #86. The documentation also included the following: Staff #86 was physically more forceful than needed when providing care, raised her voice and used profanity. Staff #86 was perceived by staff and residents as being angry and frustrated. Staff #86 was involuntary terminated. An interview with the Assistant Director of Nursing (ADON/staff #36) and the Administrator (ED/staff #10) was conducted on (MONTH) 28, 2019 at 8:52 a.m. Staff #36 stated that she expects staff to report abuse or suspicion of abuse to the Executive Director, Director of Nursing (DON) or the ADON immediately. She said that all staff have been told to call the ED, DON or ADON right away if the CNA can't find the charge nurse to report abuse, and that they have been told to call until they get a hold of somebody. She stated that they have two hours to report allegations of abuse to the officials. Staff #10 stated that the allegations of abuse occurred on (MONTH) 27, (YEAR) on the night shift between 3 a.m. - 6 a.m. He stated that staff #85 reported the allegations of abuse to the day shift CNA's and that he was notified of the allegations around 8:00 a.m. The ED stated that abuse allegations are required to be reported within two hours from the point of notification, and defined notification as the time the suspected abuse happened. Review of the facility's abuse policy dated (YEAR), revealed that the facility strives to prevent the abuse of all residents. The objective is to provide a safe haven for residents through preventative measures which protect residents right to be free from abuse and neglect. The policy included that if abuse is witnessed or suspected, the ED will be notified, and the ED and the witness who is reporting will notify the State Survey Agency in accordance with timeframes and standards required by the State Agency. Prompt reporting and investigation will be utilized to identify the validity of findings and reasonable measures will be implemented to deter further incidents of abuse.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record reviews, staff interviews, facility documentation and policy and procedures, the facility failed to prevent the potential for further abuse of residents, by failing to remove a staff member from providing direct care to residents regarding allegations of abuse for 4 of 5 sampled residents (#3, #16, #244, and #292), and failed to conduct a thorough investigation regarding an incident of neglect for 1 sampled resident (#292) and failed to protect residents from the potential for further neglect. The deficient practice resulted in residents being subjected to further abuse/neglect. The deficient practice also resulted in an incident of neglect regarding an unsafe transfer not being identified or investigated, in order to determine possible causes of the fall and implement corrective action. Findings include: -Resident #292 was admitted to the facility on (MONTH) 11, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 27, (YEAR). Regarding an incident of neglect: Review of the baseline care plan-admission evaluation dated (MONTH) 11, (YEAR) under the section for ADL's (activities of daily living), revealed that resident #292 was alert and oriented x 4 and was totally dependent on two staff with transfers. The documentation included the resident had severe impairment with movement to bilateral legs and hips. Review of the ADL care plan dated (MONTH) 13, (YEAR), revealed the resident had an ADL self-care performance deficit, related to deconditioning. One of the interventions included that staff participation was required for transfers. However, the care plan did not specify how many staff were required for transfers or if mechanical lifts should be used. According to the Physical Therapy Evaluation and Plan of Treatment dated (MONTH) 14, (YEAR), the resident was totally dependent with bed mobility and transfers, and required maximum assistance. A nurses note dated (MONTH) 16, (YEAR), revealed the resident was a Hoyer lift for transfers and was totally dependent on two+ persons for assistance. According to a quarterly MDS (Minimum Data Set) assessment dated (MONTH) 25, (YEAR), the resident scored a 13 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. Per the MDS, the resident required extensive assistance of two persons with bed mobility, transfers, dressing and toilet use, and was totally dependent on two persons with transfers. A physical therapy note dated (MONTH) 4, (YEAR), revealed the resident started therapy and had needed 100% assistance, but now has improved to 20 % assistance. The note included that for bed mobility and sit to stand, the resident was a moderate assist of two persons with a front wheel walker. A nurses note dated (MONTH) 5, (YEAR) included the resident required extensive assistance of two staff members for transfers, secondary to generalized weakness and size, and utilizes a mechanical lift as needed. Review of clinical record revealed that resident #292 did not have any falls, since admission. A nurses note dated (MONTH) 6, (YEAR) revealed that a CNA (certified nursing assistant/staff #18) transferred the resident alone by herself from the bed to the wheelchair, with the help of a walker. While attempting to sit into the wheelchair, the resident slid to the floor on her knees. The note included that two staff members (CNA #18 and nurse #56) with the help of a sit/stand Hoyer lift assisted the resident from the floor to the wheelchair. The resident had no injuries except for a right hip old superficial blister, which had popped and a dressing was applied. Review of the IDT review note dated (MONTH) 7, (YEAR), revealed a non-injury fall related to weakness during transfer and resident placed on alert charting. Further review of the clinical record revealed the resident was discharged on (MONTH) 27, (YEAR). The facility was unable to provide any evidence that the incident of neglect was thoroughly investigated or that staff #18 was removed from providing direct care to residents, pending an investigation. An interview with a physical therapy assistant (PTA/staff #58) was conducted on (MONTH) 26, 2019 at 12:58 p.m. At this time, the therapy notes were reviewed with staff #58, who stated the resident was a two person transfer at the time of the fall. She said that since the resident was transferred from the bed to a standing position, it would require two persons. An interview with the Assistant Director of Nursing (ADON/staff #36) and the Executive Director (ED/staff #10) was conducted on (MONTH) 28, 2019 at 8:52 a.m. She stated that it would be neglect if staff were not following the care plan or therapy orders for transfers. Staff #36 said she would expect the CNA's to follow what therapy recommends for transfers. At this time, the fall documentation was reviewed with staff #36. She stated that during an IDT meeting (which included the DON, ADON, the Care Coordinator and therapy), it was not identified that the fall was an unsafe transfer. Staff #36 said that since they did not identify the incident as neglect, and they did not report the incident or investigate it. The ADON also stated that when there is an allegation of abuse/neglect, the first priority is to protect the resident by removing the alleged perpetrator. She stated that if the alleged perpetrator is a staff member, the staff is asked to leave the building. Regarding an allegation of abuse for resident #292: Review of a facility's investigation report revealed that on (MONTH) 27, (YEAR) on the night shift between 3-6 a.m., a CNA (staff #85) witnessed another CNA (staff #86) telling resident #292 to shut up and threaten to drop the resident if she did not stop swinging her arms around, while changing the resident's brief. Staff #85 reported the resident was reaching her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035118	A. BUILDING _____ B. WING _____	**03/28/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF CAMP VERDE	**86 WEST SALT MINE ROAD CAMP VERDE, AZ 86322**

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 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) arms out, because she was afraid of falling and wanted help. Staff #85 reported that staff #86 told the resident that if she hits her, I will drop you. The investigation included a written interview with staff #86, who said that on (MONTH) 27, (YEAR) she yelled at resident #292, because the resident was afraid of falling and she needed to calm down. Staff #86 stated that she told the resident that she might drop her if she did not calm down or if she hit her. The investigation report also included an interview with resident #292's roommate, who stated that on (MONTH) 27, (YEAR) she heard resident #292 yelling, because she was scared that she was going to fall out of bed. The roommate stated that she heard one of the staff tell the resident to shut-up or be quiet. The roommate stated that she was upset and did not like what was happening. Further review of the facility's report revealed there was no evidence that staff #86 was immediately removed from providing care to residents. -Resident #16 was admitted to the facility on (MONTH) 6, (YEAR), with [DIAGNOSES REDACTED]. Review of the facility's investigation report revealed that on (MONTH) 27, (YEAR) during the night shift between 3:00 a.m. and 6:00 a.m., a CNA (staff #85) witnessed another CNA (staff #86) swearing and handling resident #16 rough, when changing the resident's brief. The report included that staff #85 had asked staff #86 to help her change the resident's brief. Staff #85 reported that while changing the resident's brief, staff #86 said that she did not know why the resident waits so long to pee, while grabbing and yanking the resident towards her. Per the report, staff #86 also hurriedly turned the resident on her side, so she could change the resident's sheets. Staff #85 reported that she thought staff #86 intended to be mean and that staff #86 had been frustrated all night. The resident reported that she was awakened by staff and that staff #86 was saying damn it or God damn it because her bed was wet. The resident said that staff #86 shoved her hard to the side while changing her sheets and that she knew staff #86 was mad, because her bed sheets were wet. The investigation also included a written interview with staff #86 who stated that she was swearing while in the resident's room, because she was frustrated. Staff #86 reported that she said crap and may have said sh Staff #86 said that she could see how the resident may have thought that she was swearing at her and that she did not mean to shove and push the resident onto her side and back at medium speed, while changing the resident's sheets. An interview was conducted with resident #16 on (MONTH) 27, 2019 at 2:29 p.m., who stated that staff #86 came into her room on (MONTH) 27, (YEAR) and shoved her so hard that she hit the bedrail. The resident stated that she was not hurt, but she was humiliated. She said staff #86 was angry and swearing because her bed was wet. She also stated that another CNA (staff #85) was present, but did not say anything. Further review of the facility's report revealed there was no evidence that staff #86 was immediately removed from providing care to residents. -Resident #244 was admitted on (MONTH) 24, (YEAR) and readmitted on (MONTH) 31, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 4, (YEAR). Review of the facility's investigation report revealed that on (MONTH) 27, (YEAR) on the night shift between 3:00 a.m. and 6:00 a.m., staff #85 asked staff #86 to help her change resident #244's brief. Staff #85 was having difficulty because resident #244 pulled her pants up and said that she was cold. Staff #86 told staff #85 that she was going to show her a trick. Staff #86 then proceeded to pull the resident's pants down, tore open the brief, forced the resident to roll over, and pried the resident's legs apart. Staff #85 stated that she felt that staff #86 forced the resident to roll over. Staff #85 reported that staff #86 told the resident to open her legs and then told staff #85, I kind of forced her to open her legs. The resident then said that she wanted to be left alone. Staff #85 said she believed that staff #86 was trying to be mean, had been frustrated all night and forced resident #244 to open her legs. The report included an interview with resident #244, but she was unable to remember anything that occurred on (MONTH) 27. The facility was unable to provide any documentation that staff #86 was immediately removed from providing care to residents.-Resident #3 was readmitted to the facility on (MONTH) 1, (YEAR), with [DIAGNOSES REDACTED]. Review of the facility's investigation report revealed that on (MONTH) 27, (YEAR) on the night shift between 3:00 a.m. and 6:00 a.m., staff #85 reported that she and staff #86 woke resident #3 up to change his brief. Staff #85 said the resident was having trouble standing up, so staff #86 told the resident Fine, you don't get changed tonight and left the room. The investigation report included a written interview with staff #86, who reported that she yelled at the resident to get him to stand up. She stated that she was frustrated, because the resident was not helping her change his brief. The report included that staff #86 stated that she cannot control the volume or tone of her voice. Further review of the investigative report revealed no evidence that staff #86 was immediately removed from providing care to residents. Continued review of the investigative findings regarding the allegations of abuse for resident #3, #16, #244 and #292, revealed they all occurred on the night shift on (MONTH) 27, (YEAR) sometime between 3 a.m. - 6 a.m. and involved staff #86. The documentation also included the following: Staff #86 was physically more forceful than needed when providing care, raised her voice and used profanity. Staff #86 was perceived by staff and residents as being angry and frustrated. Staff #86 was involuntary terminated. An interview was conducted on (MONTH) 28, 2019 at 8:52 a.m. with the Assistant Director of Nursing (ADON/staff #36) and the Executive Director (staff #10). Staff #10 stated that the allegations of abuse occurred on (MONTH) 27, (YEAR) on the night shift between 3 a.m. - 6 a.m. Staff #10 stated that the alleged perpetrator worked until the end of her shift, which ended at 6:00 a.m. He stated that staff #85 reported the allegations of abuse to the day shift CNA's and that he was notified of the allegations around 8:00 a.m. The ADON stated that during new hire orientation, staff receive abuse training and the first priority is to protect the resident, by removing the staff member involved. She said that the staff who witness an allegation of abuse is expected to ask the alleged perpetrator to leave the building. Review of the facility's abuse policy dated (YEAR), revealed that the facility strives to prevent the abuse of all residents. The objective is to provide a safe haven for residents through preventative measures which protect residents right to be free from abuse and neglect. If abuse/neglect is witnessed or suspected, the resident's safety will immediately be secured and the ED will be notified. If staff is suspected of being the abuser, they will be suspended until the investigation is complete. Prompt reporting and investigation will be utilized to identify the validity of findings and reasonable measures will be implemented to deter further incidents of abuse. The policy also included the ED will begin an investigation immediately and will complete the investigation within 5 days using the abuse investigation packet. A minimum of 3 residents will be interviewed in order to determine if there is a trend. Staff members will document their own statements and sign and date them. The policy included that all abuse investigation information will be documented and kept in an abuse investigation binder. -