STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035091	A. BUILDING _____ B. WING _____	**01/24/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF FLAGSTAFF	**800 WEST UNIVERSITY AVENUE FLAGSTAFF, AZ 86001**

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

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure one resident (#5) was free from abuse by another resident (#37). Findings include: -Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated [DATE] included that the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive deficits. The MDS also included that the resident needed a two person assist for bed mobility and for transfers into her wheelchair. The MDS coded that the resident did not have any behaviors toward others at the time of the assessment. Review of the resident's fall care plan included that the resident had gait and balance difficulties and a goal that she be free from injuries. A review of the nurses notes dated 10/16/2018 included that resident #5 said, Yes, I hit (resident #37) with my brush after she hit me first. -Resident #37 was admitted on [DATE] with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated [DATE] included that the resident had a BIMS score of 15 and was a one person assist with bed mobility and transfers. The MDS coded that the resident did not have any behaviors toward others at the time of the assessment. The nursing notes for 10/16/2018 noted that resident #37 reported to the nurse that resident #5 hit her with a brush for no reason. Resident #5 was asked if she hit resident #37 and she admitted she did hit resident #37 but only after she was hit by resident #37 first. Resident #37 then admitted she hit resident #5 first. A review of the facility's investigation dated 10/19/2018 revealed that on 10/15/18 at 8:37 PM, resident #37 reported that resident #5 hit her on the arm with her hair brush. A Licensed Practical Nurse (LPN/Staff #100) assessed the resident's arm and found no signs of injury. The LPN then spoke to resident #5 and she admitted she did hit resident #37 after resident #37 hit her first. The investigation also included that resident #37 admitted to hitting resident #5 first. No specific reason for the altercation was revealed by either resident. An interview was conducted on 1/23/19 at 10:55 AM with resident #5. She stated that she does not remember the incident but does remember (resident #37) used to be her roommate. She added that she has no bad feelings towards resident #5. In an interview with resident #37 on 1/23/19 at 12:20 PM, the resident stated that she does not remember the incident or having hit anyone. An interview was conducted on 01/24/19 at 1:45 PM with the Director of Nursing (DON/staff #13). The DON stated that she did investigate the incident and both residents admitted to the altercation. She also said that resident #37 did admit she hit resident #5 first, but could not explain why. She added that the residents were separated and stayed in separate rooms that evening and were monitored by staff as per protocol. She included that there were no previous incidents between the residents prior to the alleged incident. During an interview conducted on 01/24/19 at 02:01 PM with an LPN (staff #100), she stated that resident #37 approached her while she was in the hallway and stated that resident #5 hit her with a brush. She said she then went into the room and spoke with resident #5 who stated that she did, after resident #37 hit her first. Resident #37 admitted that she did hit resident #5 first because she was not being nice. Staff #100 stated that she separated the residents and assessed each one for injuries and none were present. She then added that she called the DON and reported the incident. Staff #100 concluded that the resident #37 stayed the night in another room in another hall, both residents were monitored all night, and that neither resident appeared upset or traumatized after the incident. Staff #100 also stated that while the two residents did occasionally speak loudly to each other, they appeared happy with each other and there were no physical contact between the residents prior to the incident. A review of the abuse policy noted that the facility strives to prevent abuse of residents and that abuse in any form will not be condoned. It also stated that the goal is to provide a safe haven for the residents and that the resident's right to freedom of abuse will be upheld by preventative measures.
F 0604 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, staff interviews, and facility policy review, the facility failed to ensure one resident (#324) was free from a physical restraint. Findings include: Resident #324 was admitted to the facility on (MONTH) 21, (YEAR) with [DIAGNOSES REDACTED]. An admission Minimum Data Set (MDS) assessment dated (MONTH) 28, (YEAR) revealed the resident was severely cognitively impaired, required extensive assistance by one or more staff for Activities of Daily Living (ADLs), and had a history of [REDACTED]. Review of the resident's care plan included no evidence that a restraint was to be in use for the resident. An interdisciplinary team fall review dated (MONTH) 29, (YEAR) revealed the resident had a fall on (MONTH) 28, (YEAR) at 7:26 p.m. and experienced a minor injury, a skin tear to the left arm. Review of facility investigation documentation dated (MONTH) 2, (YEAR) included that on (MONTH) 29, (YEAR), the Director of Nursing (DON/staff #13) was alerted that a gait belt may have been used inappropriately on the resident's wheelchair which initiated an investigation. The report indicated that the resident had a history of [REDACTED]. The resident was also noted to have a history of dementia and cognitive impairments. During the investigation it was determined that on (MONTH) 28, (YEAR), the gait belt was observed around the waist of the resident and the wheelchair. All staff on that shift were interviewed and it was determined that a night nurse had placed the gait belt around the resident's waist in an attempt to assist with positioning. All staff who were identified as observing the gait belt being utilized as a restraint were given a final written warning for failure to report a potential violation of policy and resident's rights. The night nurse (staff #141) admitted to utilizing the gait belt as a positioning device in an attempt to keep the resident safe.

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 0604 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Further review of the facility investigation revealed witness statements from the following staff: -A Registered Nurse (RN/staff #94) who included that the resident had sustained a fall earlier in the shift and was subsequently observed to keep trying to stand up out of his wheelchair. The RN stated, I am unsure of the time, but at one point in the night a gait belt was put on the resident in a restraining fashion for his safety. The gait belt was put on by the other nurse that was working that night, which was (staff #141). -The DON who questioned staff #141 regarding the gait belt and he admitted that he had used a gait belt to secure the resident in a wheelchair because he was concerned the resident would slide out of the wheelchair and potentially hurt himself. Further, she noted she requested him to sign a written warning and complete a witness statement, which he did not do and was informed that he failed to comply with the investigation. -A Certified Nursing Assistant (CNA/staff #140) noted that she arrived to work on (MONTH) 28, (YEAR) around 10:00 p.m. when she noticed resident #324 was in a wheelchair with a gait belt around him and the wheelchair. -A CNA (staff #142) included that she was rounding on (MONTH) 28, (YEAR) and witnessed the resident fixed to his wheelchair with a gait belt. Review of the clinical record revealed no evidence the resident had an order from a physician to be restrained in any way. Attempts to contact staff #141 via telephone were unsuccessful. In an interview with the DON (staff #13) on (MONTH) 23, 2019 at 10:59 a.m., she stated the morning this was discovered, she became aware because a staff member reported to her that resident #324 was observed to have a gait belt around the back of his wheelchair. At that time the resident was not observed to have the gait belt around him, however she began an investigation to find out why the gait belt was around the resident's chair in the first place. She stated, through interviews, she was able to determine there were witnesses who observed the gait belt around the resident in a restraining manner. She stated the night nurse (staff #141) was determined to be the one who put the gait belt on the resident and he admitted to doing it to keep the resident from falling. Further, she stated staff #141 refused to come in and give a written statement or sign his disciplinary action. She stated, ultimately, staff #141 was terminated. She stated a lot of education was done after this incident regarding restraints and reporting. In a phone interview with an RN (staff #94) on (MONTH) 23, 2019 at 12:04 p.m., he stated he remembers this resident and the incident. He stated the resident had been attempting to get out of is wheelchair a lot and it was not safe. He stated the other nurse working, staff #141, put the gait belt around the resident for safety reasons and not in a malicious manner. Further, he stated he took the gait belt off when he helped put the resident to bed later in the shift. In a phone interview with a CNA (staff #140 and a previous employee) on (MONTH) 23, 2019 at 12:09 p.m., she stated that she remembers this incident as she came into work around 10:00 p.m. and she saw resident #324 seated in front of the nurses station with a gait belt around his waist and the back of the wheelchair he was sitting in. She stated she asked the nurse (whose name she did not remember) about it and the nurse suggested they get him into bed. She stated they then unbuckled the gait belt and took the resident to his room and lay him down in his bed. Further, she stated she got him up and ready in the morning and did not reapply the gait belt to the resident. She stated she had thought the gait belt was being used inappropriately. In an interview with the DON (staff #13) on (MONTH) 23, 2019 at 2:35 p.m., she stated her expectation of staff is not to use any device to secure a resident. She stated if staff witness a resident being restrained, they are to report it immediately. Review of a facility policy titled, Restraint Use Policy included that the facility, strives to be a restraint free environment .Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, staff interviews, and policy review, the facility failed to follow their abuse policy for two residents (#5) and (#37). Findings include: -Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated [DATE] included that the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive deficits. The MDS also included that the resident needed a two person assist for bed mobility and for transfers into her wheelchair. The MDS coded that the resident did not have any behaviors toward others at the time of the assessment. -Resident #37 was admitted on [DATE] with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated [DATE] revealed that the resident had a BIMS score of 15 and that the resident was a one person assist with bed mobility and transfers. The MDS coded that the resident did not have any behaviors toward others at the time of the assessment. A review of the facility's investigation dated 10/19/18 revealed that on 10/15/2018 at 8:37 PM resident #37 reported that resident #5 hit her on the arm with her hair brush. The Licensed Practical Nurse (LPN/Staff #100) assessed the resident's arm and found no signs of injury. The nurse then spoke to resident #5 and she admitted she did hit resident #37 after resident #37 hit her first. The investigation also included that resident #37 admitted to hitting resident #5 first. No specific reason for the altercation was revealed by either resident. Further review of the investigation revealed no evidence that Adult Protective Services (APS) was notified of the allegation. An interview was conducted on 01/24/19 at 1:45 PM with the Director of Nursing (DON/staff #13). The DON stated that she did investigate the incident and both residents admitted to the altercation. The DON admitted that she knows the facility's policy is to report the allegation, however after speaking with the resident's families, she felt it was not necessary to notify APS because neither the families nor the residents wanted the incident reported. An interview was conducted on 01/24/19 at 02:01 PM with an LPN (staff #100). The nurse stated that she was unaware if APS had been notified but she believes that the facility policy states that they should be and she left this up to the DON. Review of the facility's abuse policy revealed that if abuse is witnessed or suspected, reporting and investigation will take place and the incident will be reported by the Executive Director or the DON to APS. The policy did not indicate that APS would be notified within 2 hours as requied.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, staff interviews, and policy review, the facility failed to report an allegation of abuse to Adult Protective Services (APS) for two residents (#5) and (#37). Findings include: -Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated [DATE] included that the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive deficits. The MDS also included that the resident needed a two person assist for bed mobility and for transfers into her wheelchair. The MDS coded that the resident did not have any behaviors toward others at the time of the assessment. -Resident #37 was admitted on [DATE] with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated [DATE] included that the resident had a BIMS score of 15 and was a one person assist with bed mobility and transfers. The MDS coded that the resident did not have any behaviors toward others at the time of the assessment. A review of the facility's investigation dated 10/19/18 revealed that on 10/15/2018 at 8:37 PM resident #37 reported that resident #5 hit her on the arm with her hair brush. The Licensed Practical Nurse (LPN/Staff #100) assessed the residents and found no signs of injury. The nurse then spoke to resident #5 and she admitted she did hit resident #37 after resident

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) #37 hit her first. The investigation also included that resident #37 admitted to hitting resident #5 first. No specific reason for the altercation was revealed by either resident. Further review of the investigation revealed no evidence that APS was notified of the allegation. An interview was conducted on 01/24/19 at 1:45 PM with the Director of Nursing (DON/staff #13). The DON stated that she did investigate the incident and both residents admitted to the altercation. She also said after speaking with the resident's families, she felt it was not necessary to notify APS because neither the families nor the residents wanted the incident reported. An interview was conducted on 01/24/19 at 02:01 PM with an LPN (staff #100). The nurse stated that she was unaware if APS had been notified and she left this up to the DON. Review of the facility's abuse policy revealed that if abuse is witnessed or suspected, reporting and investigation will take place and the incident will be reported by the Executive Director or the DON to APS. The policy did not indicate that APS would be notified within 2 hours as requied.