STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035233	A. BUILDING _____ B. WING _____	**10/25/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF GLOBE	**1100 MONROE STREET GLOBE, AZ 85501**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and review of policy, the facility failed to ensure advance directives were consistent for one of 19 sampled residents (#25). The deficient practice could result in residents' directives not being honored. Findings include: Resident #25 was admitted to the facility on (MONTH) 2, (YEAR), with [DIAGNOSES REDACTED]. In a review of a binder, located at a central nursing station, was an advance directive paper form for resident #25. Included on this form was the resident's name and signature of the resident's responsible party dated (MONTH) 24, 2019. The section for cardiopulmonary resuscitation (CPR) that included FULL CODE was checked, which indicated the resident wanted CPR if his breathing and heart stopped. However, review of the electronic record revealed a physician's orders [REDACTED]. An interview was conducted on (MONTH) 24, 2019 at 9:05 a.m. with a Licensed Practical Nurse (staff #45). She stated the paper form for the advance directives for resident #25 indicated the resident was a FULL CODE and the electronic system indicated the resident was a DNR. Staff #45 stated this was a problem because the two advance directives do not match. She stated the inconsistencies needed to be corrected right away. An interview was conducted with the Director of Nursing (DON/staff #12) on (MONTH) 24, 2019 at 9:08 a.m. He stated the expectation is that all documentation related to advance directives be consistent. He said the information could be found in two locations, the binder at the nursing station and the electronic record. Staff #12 further stated that because the nurses could refer to either, it is important the advance directives be consistent in accordance with the resident/responsible party wishes. The facility's policy regarding advance directives revised (MONTH) 2013, revealed advance directives will be respected in accordance with state law and facility policy. The DON or designee will notify the attending physician of advance directives so that appropriate orders can be documented in the resident's clinical record. Inquiries concerning advance directives should be referred to the administrator, DON, and/or the Social Services Director.
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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, resident and staff interviews, facility documentation and policy review, the facility failed to ensure two residents (#229 and #30) were free from abuse involving residents (#56 and #46). The deficient practice has the potential for further abuse. Findings include: Regarding residents #30 and #46 -Resident #30 was admitted on (MONTH) 14, (YEAR) with [DIAGNOSES REDACTED]. The quarterly MDS (Minimum Data Set) assessment dated (MONTH) 15, 2019 revealed the resident had a BIMS (Brief Interview for Mental Status) score of 9 indicating the resident had moderate cognitive impairment. An incident note dated (MONTH) 30, 2019 revealed that at approximately 5:00 p.m., resident #30 and resident #46 were in the hallway exiting their rooms. Resident #46 was sitting in his wheelchair in front of resident #30, yelling at and trying to hit resident #30 who was trying to get away. Per the documentation, resident #46 grabbed and scratched resident #30. Review of the alert charting note dated (MONTH) 1, 2019 included the resident (#30) was involved in an altercation with another resident (#46) resulting in a superficial scratch to her leg. -Resident #46 was admitted on (MONTH) 29, (YEAR) with [DIAGNOSES REDACTED]. Review of the care plan initiated (MONTH) 5, (YEAR), revealed the resident had the potential to demonstrate verbally abusive behaviors related to ineffective coping skills and poor impulse control related to [MEDICAL CONDITION]. The goal was the resident will have zero verbal aggression episodes. Interventions included analyzing and documenting key times, places, circumstances, triggers, and what de-escalates behavior; ensuring the hallways are clear while resident wheels self through the hallway; and intervening before agitation escalates and guiding the resident away from the source of distress. The quarterly MDS assessment dated (MONTH) 31, 2019 revealed the resident had long-term and short-term memory problem and had moderately impaired cognitive skills for daily decision making. The alert charting note dated (MONTH) 30, 2019 revealed resident #46 was involved in a resident to resident altercation and was verbally abusive towards the other resident (#30). The alert charting note dated (MONTH) 1, 2019 included resident #46 was involved in altercation with a female resident (#30) during day shift, was noted to be the aggressor, and had contact with the female resident resulting in a small superficial scratch to the female resident's leg. Review of the facility's investigative report revealed that at approximately 5:00 p.m. on (MONTH) 30, 2019, resident #30 was attempting to propel herself in her wheelchair out of her room and resident #46 was in his wheelchair propelling himself across the hallway to the side where resident #30 was attempting to leave her room. According to the report, the police interview with resident #30 revealed that both wheelchairs ran into each other. The report included a Certified Nursing Assistant (CNA) witnessed resident #46 initiate the verbal and physical aggression towards resident #30 and that resident #30 sustained a scratch to the lower left extremity that was treated by the floor nurse. The report included an interview with the CNA (staff #84) that witnessed the incident. The CNA stated resident #30 was in her wheelchair trying to come out of her room and resident #46 was trying to get through as well. Resident #46 got mad, cussed at resident #30 and tried to hit her. Per the interview, resident #30 was trying to get away when resident #46 grabbed her. The CNA stated she separated the two residents and noticed a scratch on resident #30's leg. The report included an interview with resident #46 who stated he was attempting to cross the hallway to get to the dining room door when he and resident #30 got into an altercation. The interview included resident #46 said he was upset and could not recall the rest of the incident.

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** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) Continued review of the report revealed an interview with resident #30. Resident #30 stated resident #46 attacked her and scratched her leg. During an interview conducted with resident #30 on (MONTH) 21, 2019 at 12:49 p.m., resident #30 stated she got into an altercation with resident #46. She stated she was attempting to leave her room to go to the dining room and had to move resident #46's wheelchair because it was in her way. She said resident #46 reached out and scratched her. Another interview was conducted with resident #30 on (MONTH) 23, 2019 at 1:01 p.m. Resident #30 stated resident #46's room is right across from her room. She stated resident #46 was in his wheelchair just outside of her room door. She said she was in the process of wheeling herself out of her room and into the hallway when her wheelchair got caught with resident #46's wheelchair. Resident #30 stated resident #46 became upset with her, called her a [***] and scratched her left knee. An interview was conducted on (MONTH) 24, 2019 at 9:06 a.m. with the CNA (staff #84) who stated she was walking down the hallway from the dining room when she saw two residents at the double doors located on the hall. She said resident #30 was in her wheelchair propelling into the hallway and resident #46 was in his wheelchair coming from his room propelling to the handrail where resident #30 was. She stated resident #46 usually uses the handrail to assist him in self-propelling his wheelchair. The CNA stated resident #30's right leg was blocking resident #46 from the handrail and that resident #46 became upset, started cussing at resident #30 and grabbed her leg resulting in a scratch to resident #30's upper leg area. She said resident #30 was telling resident #46 to leave her alone and was trying to push him away as he was grabbing her. The CNA stated the residents were separated but that resident #46 continued to be upset. During an interview conducted with resident #46 on (MONTH) 24, 2019 at 2:53 p.m., resident #46 stated that he does not recall any incident or altercation with a female resident and he does not recall scratching another resident's leg. During an interview conducted with the administrator (staff #111) on (MONTH) 25, 2019 at 9:52 a.m., he stated the incident between resident #30 and #46 was identified as resident to resident abuse. Regarding residents #229 and #56 -Resident #56 was admitted to the facility on (MONTH) 17, (YEAR), with [DIAGNOSES REDACTED]. Review of a quarterly MDS assessment dated (MONTH) 12, 2019 revealed a BIMS score of 11 which indicated the resident had moderately impaired cognition. -Resident #229 was admitted to the facility on (MONTH) 17, 2019, with [DIAGNOSES REDACTED]. Review of a Licensed Practical Nurse (LPN/staff #40) progress note dated (MONTH) 19, 2019 revealed resident #229 and his roommate (resident #56) were not getting along. The note included resident #229 stated his roommate threatened to have his people come and kill him tomorrow and that staff was present. The CNA stated that did not happen. The note included that this was reported to the charge nurse. The note also revealed the resident (#229) finally laid down in bed after he was reassured staff would be checking on both residents all night. An interview was conducted with resident #229 on (MONTH) 21, 2019 at 11:45 a.m. Resident #229 stated his roommate (resident #56) threatened to kill him. He stated that he thought it happened on Saturday, (MONTH) 19, 2019 around dinner time as he was eating at the time. Resident #229 stated that the nurse (he was unable to identify which nurse) was with him and heard the threats made by resident #56. Resident #229 stated he was in his wheelchair with his back to the privacy curtain and that when he rolled back, he bumped into resident #56's wheelchair on the other side of the curtain. Resident #229 stated that resident #56 stated don't hit my f***ing vehicle and I'll f***ing kill you. Resident #229 stated that resident #56 also said that he would call his family to take care of him (resident #229) when resident #229 was asleep. Resident #229 stated that his nurse said that she would talk with the resident #56 and that there had been no further issues with the other resident. The allegation of resident to resident abuse that allegedly occurred on (MONTH) 19, 2019, was reported to the administrator (staff #111) by two members of the survey team on (MONTH) 21, 2019 at 1:05 p.m. The administrator stated that he did not have any knowledge of the incident between resident #56 and resident #229. Review of the facility's investigative report revealed that an allegation of resident abuse was made on (MONTH) 19, 2019 and was reported to the State Agency and the police on (MONTH) 21, 2019. Resident #229 stated he bumped his wheelchair into his roommate (resident #56) by accident and that the roommate cussed him out and threatened him. Further review of the facility's investigative report revealed the following witness statements: -CNA (staff #86) was the primary CNA caring for the residents. She said she was present in the residents' room when the argument started. When asked if resident #56 ever threatened resident #229, she said no, he never said those words. She said resident #56 was very upset and said resident #229 kept coming to the side of his bed ramming his wheelchair into his and it was disturbing him. Resident #56 told resident #229 to stop doing it, but resident #229 continued and that's why he yelled and cussed at him to stop doing that. -Resident #229 was interviewed and asked what occurred, he stated that he was in the room and had just received his dinner tray when he went to turn around in his wheelchair to get something out of the drawer. He said the curtain divider was separating him and his roommate and when he turned with his wheelchair he accidentally bumped into his roommate's wheelchair. This caused his roommate (resident #56) to become upset and yell at him and begin cussing at him. He said that resident #56 threatened to have people come and kill him if he did not stop and told him to get the f**k out of the room. -Resident #56 was unable to be interviewed at the time because resident #56 was very upset and mad that the police were called when it was resident #229 fault. Review of a room and/or roommate change notice form, dated (MONTH) 21, 2019, revealed that resident #229 changed rooms for the reason of safety. An interview was conducted with resident #56 on (MONTH) 23, 2019 at 12:59 p.m. (In response to the question Have you ever threatened another resident?) He stated Yes I did, and identified resident #229, he was repeatedly bumping into my wheelchair and I told him that I would probably kill him if he kept it up. He stated that a staff member CNA #86 was present when it happened. He stated that it happened Saturday (October 19, 2019) and that he had no intention of harming resident #229, but was just very frustrated. An interview was conducted with the LPN (staff #40) on (MONTH) 24, 2019 at 8:43 a.m. She stated that she worked on Saturday (MONTH) 19, 2019 and that residents #56 and #229 were her residents. She stated that she was not present when the residents were arguing, but that the CNA (staff #86) had reported to her that while she was in the room, the two residents were fighting because resident #229 was running into resident #56's wheelchair and table and pulling on the privacy curtain and that resident #229 had run into the CNA's leg and was being aggressive. The LPN stated that the CNA stated that resident #56 said quit running into my vehicle and that the CNA did not report any yelling, cursing, or threats. Staff #40 stated that resident #229 came out of his room and told her that he was not going back into the room again because resident #56 said he was going to call his people and have him murdered. She stated that she asked resident #56 what had happened and that he stated that resident #229 was continually crashing into his vehicle, the table, and pulling the privacy curtain, however, she stated that she did not ask resident #56 specifically if he had threatened resident #229. She stated that as resident #229 reported to her that resident #56 had threatened him she thought that is would be potential abuse and reported it to her charge nurse (Registered Nurse (RN)/staff #115). She stated that she told the Assistant Director of Nursing (ADON/staff #72) the next morning. An interview was conducted with the CNA (staff #86) on (MONTH) 24, 2019 at 9:33 a.m. She stated that on Saturday (MONTH) 19, 2019, she answered a call light for resident #56 and that he pointed to the other bed but that resident #229 stated he did not need anything so she went back to resident #56. She stated that resident #56 told her that resident #229 kept running into his stuff (his vehicle and his desk) and that he did not appreciate it. She stated that resident #56 told resident #229 that If you keep f***ing doing this, I am going to f'***ing hurt you. Staff #86 stated that resident #229 stated that is a threat two times and followed her out of the room and stated that he was not going back into the room. Staff #86 stated that she let the nurse know that residents #56 and #229 were not getting along and that resident #56 told resident #229 that he would hurt him if he kept bumping into his stuff. She stated that resident #229 was seen talking to the nurse. She stated that the situation was a potential abuse, kind of, as you should not say that to someone and that is why she told the nurse. An interview was conducted with the ADON (staff #72) on (MONTH) 24, 2019 at 10:19 a.m. She stated that staff receives training on abuse at least yearly and includes instructing staff to report a potential abuse allegation to the abuse officer, Director of Nursing, or ADON. She stated that if the CNA witnessed a potential abuse of one resident threatening another, she should have made sure the residents were separated and safe and told the immediate supervisor so that the

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F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) situation would be reported and investigated. An interview was conducted with the administrator (staff #111) on (MONTH) 25, 2019 at 9:19 a.m. He stated that staff receives training on abuse in the monthly all staff meetings and throughout the year as well as in new hire orientation. He stated that training includes types of abuse and reporting. He stated that he is the abuse coordinator and that any suspected abuse should be reported to himself or the DON immediately. The administrator stated that any threat to murder/kill/harm should be identified as a potential abuse. Review of the facility's policy on resident rights revealed residents have the right to be free from abuse, neglect, misappropriation of property, and exploitation and have the right to be supported by the facility in exercising his or her rights and have the right to have the facility respond to his or her grievances. Review of the facility's policy on abuse revealed they strive to prevent the abuse of all their residents and recognize that they care for residents with the [DIAGNOSES REDACTED]. The policy included that abuse includes verbal abuse, mental abuse, and physical abuse and that potential abusers can be residents. The policy stated that the objective is to provide a safe haven for our residents through preventative measures that protect every resident's right to freedom from abuse and that if abuse is witnessed or suspected the resident's safety will immediately be secured. In addition, 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 included that education would be provided regarding abuse prevention, recognition, and reporting procedures. The abuse policy definitions included that physical abuse includes, but is not limited to, hitting, kicking, grabbing, scratching, pushing/shoving, biting, threatening gestures, and throwing objects. The definition for verbal abuse includes, but is not limited to yelling, screaming, cursing, bossing around/demanding, insulting to race or ethnic group, intimidating. The definition of mental abuse included intent to threaten.
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, staff interviews, and review of facility documentation and policies, the facility failed to ensure one sampled resident (#75) was free from physical restraints. The deficient practice could result in residents being restrained. Findings include: Resident #75 was admitted to the facility on (MONTH) 2, 2019 with [DIAGNOSES REDACTED]. Review of a nursing alert charting note dated (MONTH) 2, 1019, revealed the resident arrived via stretcher. The resident was alert but not oriented and his speech was unclear and garbled. The note included the resident was unable to participate in any of the assessment questions. The note also included the transportation driver reported that he had to pull over at a gas station because the resident was attempting to pull his Foley catheter out. Review of the care plan revealed the resident was high risk for falls related to gait and balance problems and had a fall on (MONTH) 2, 2019 with no injury. The care plan included an intervention to ensure the resident was wearing appropriate footwear. Review of the facility investigative report dated (MONTH) 8, 2019 revealed that on (MONTH) 3, 2019 at approximately 8:00 a.m. during a routine skin check, a wound Licensed Practical Nurse (LPN/staff #19) found resident #75 in bed with a sheet over him. The sheet was removed and the resident was found to have another bed sheet placed over the chest of the resident which was looped through a bed cane on each side of the bed and was secured. The LPN removed the sheet, an investigation was initiated, and the incident was reported to the appropriate parties. The report included an interview with the Registered Nurse (RN/staff #112) who was the primary nurse caring for resident #75 during the evening shift of (MONTH) 2, 2019 through the morning of (MONTH) 3, 2019. Staff #112 stated the resident had been attempting to get up out of bed all night and at one point did have a fall. Staff #112 stated the resident was unable to be redirected and because he was such a high fall risk she was in fear that he would fall and have a major injury. The RN stated the resident was confused and had attempted to get out of bed numerous times. Staff #112 stated that she went to her last resort and placed a sheet over the resident because she did not want him to fall or injure himself. She further stated she was thinking of the resident's safety and that she had gone into his room countless times to check on him to make sure he was okay. Staff #112 stated she did not tie the sheets to the bed canes but rather placed the sheet through the bed cane and left it loose enough so that the resident could get out if he attempted to. Staff #112 stated she did this for the safety of the resident and wanted to make sure he did not injure himself. Also included in the report was an interview with the Certified Nursing Assistant (CNA/staff #113) who worked during the evening shift of (MONTH) 2, 2019 through the morning of (MONTH) 3, 2019. The CNA was the primary CNA caring for resident #75. Staff #113 stated the resident had been inconsistent with his behavior all night and had a fall that evening which promoted the discussion of how to keep the resident safe from injuring himself. She said a fall mat was in place bed but that the resident continued to get up unassisted and was at high risk for falling. Staff #113 stated the resident could not understand or be instructed on safety measures. The CNA stated she was told by the RN (staff #112) to place a sheet over the resident's chest and tie it to the top of the bed canes to help prevent the resident from getting up. Staff #113 stated she did not tie the sheet to any of the bed canes but watched staff #112 place the sheet over the resident's chest and tied them to the top of the bed canes. Staff #113 stated she checked on the resident frequently throughout the night and assisted him in changing his briefs as well as emptying his urinal. She stated the resident had no complaints or discomfort and that resident #75 slept all night. The report also included an interview with the wound LPN (staff #19). She stated that during her morning rounds, she went to the resident #75's room to complete the post admission skin check. Staff #19 said she found the resident under his blanket resting and that when she removed the sheets, she observed a bed sheet across the resident's chest that was secured to the bed canes of the bed. Staff #19 said the resident was not in any distress or pain and was resting in bed. She stated she immediately removed the sheet and went to educated staff on the use of restraints in the facility. She immediately spoke to staff #112 and staff #113 and that they both indicated they placed the sheet over the resident to prevent him from falling and injuring himself due to his aggressive behavior, his inability to be redirected, and his high risk for falls. The facility report conclusion was that a bed sheet was placed over the resident by staff #112 and staff #113 on (MONTH) 3, 2019 to prevent the resident from falling with the intention of keeping the resident safe from injury. The staff were initially suspended and then terminated. A review of the clinical record revealed no evidence of an assessment prior to the placement of a restraint, no evidence of a physician's orders [REDACTED]. An interview was conducted with the RN (staff #112) on (MONTH) 22, 2019 at 2:20 p.m. Staff #112 stated the resident had a fall shortly after being admitted and then again was found on the floor shortly after the first fall. Staff #112 stated that once the resident was back in bed, she and the CNA (staff #113) placed a sheet across the chest area of the resident. Staff #112 stated she did not tie or knot the corners of the sheet to the side rails and further stated she told staff #113 that neither of them could tie the sheet to the rails. Staff #112 stated she checked on the resident throughout her shift and the resident appeared to be sleeping and was not trying to get out of bed. The RN stated she never looked to see if staff #113 had tied the sheet to the side rails of the bed. She stated the wound nurse (staff #19) came on duty about 5:00 a.m. on (MONTH) 3, 2019 and told her the resident had been found tied in his bed and wanted to know who did it. Staff #112 stated she told the wound nurse she had not done it. Staff #112 stated the resident could get out of bed independently and had done so numerous times during her shift. An interview was conducted with the wound LPN (staff #19) on (MONTH) 23, 2019 at 8:29 a.m. Staff #19 stated that she arrived to work about 4 a.m. and entered the room of resident #75. She stated he was lying quietly in his bed and was alert but not oriented. Staff #19 stated she spoke to him and reached to pull off the sheet and instantly realized each corner of the top of the sheet was tied to the bed cane that was on both sides of the bed. Staff #19 stated she left the room after she untied the sheet and went to find the staff who had worked with the resident during that shift. Staff #19 stated she found staff #113 and asked her if she was aware the resident had been tied down and she said yes. Staff #19 stated she asked staff #113 if she was aware the facility was restraint free and staff #113 stated she knew that. Staff #19 stated staff

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F 0604 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) #113 told her that she and staff #112 could not keep the resident from getting out of bed and that the resident was staggering and already fallen. Staff #19 stated she asked staff #113 if she had tied the resident down to his bed and staff #113 stated she did not. Staff #19 then asked staff #112 if she was aware the resident had been tied down. Staff #19 stated staff #112 told her that she and staff #113 had to tie him up because he was a fall risk, he had already fallen, and he was admitted with a surgical opening with staples on the back of his head. Staff #19 stated she told staff #112 she had removed the tight knots that were in the sheet from the bed of resident #75. Staff #19 stated staff #112 then told her she had not tied the knots too tight and that she did not know the facility was restraint free. Staff #19 stated the facility is restraint free and no resident should be tied down or restrained. An interview was conducted on (MONTH) 23, 2019 at 11:11 a.m. with the CNA (staff #113). Staff #113 stated that resident #75 had fallen that night, kept saying come on, and let us go, and I am ready. She stated she told the resident it was night time and time for bed. Staff #113 stated the resident was very confused and would not listen to the staff very well. The CNA stated the RN (staff #112) said they should tie the corners of the top sheet to the two bars on both sides of the bed so the resident could be safe in bed and not fall. Staff #113 stated she did not tie the sheet to the sides of the bed that staff #112 did it. Staff #113 stated she knew it was the wrong thing for the resident to be restrained and to keep quiet about it. She stated tying a sheet to the bed preventing a resident from getting out of bed who is able to get out of bed would be considered a restraint. Staff #113 stated because the resident was so confused she did not think he would have been able to untie or undo the bed sheet that was tied to the bars on the bed. She also stated that she had receiving training and in-services about restraints and knew the staff did not have the right to restrain a resident. A review of the personnel file for staff #112 revealed evidence of training on the use of restraints. The file also revealed staff #112 intentionally restrained a resident with a bed sheet across the chest of the resident and tied it to the bed rail without proper assessments, supervision, and without a physician's orders [REDACTED].#112 employment was being terminated effective immediately. A review of the personnel file for staff #113 revealed evidence of training on the use of restraints. Further review of the file revealed it was determined staff #113 did in fact aid in restraining a resident with a bed sheet and that staff #113 was terminated. The facility's policy on restraint use revealed the facility will strive to be a restraint free environment. Restraints shall only be used for the safety and well-being of the resident and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptoms and never for discipline or staff convenience or for the prevention of falls. Restraints can only be used if the physician order [REDACTED]. An order must be obtained for the use of restraints and must include the specific medical condition that the restraint will be used to treat, how the restraint will benefit the resident, and the type and timeframe the restraint will be used. The policy also included physical restraints are defined as any manual method of physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot easily remove which restricts freedom of movement or restricts normal access to one's body. Defining a restraint is based on the resident's functional status and not the device. If a resident is not able to remove the device and it restricts normal body movements the devices is considered a restraint. The policy further revealed inappropriate utilization of equipment to prevent mobility is considered a restraint and is not an approved practice at this facility. The facility's policy regarding resident rights included the resident has the right to be free from a physical restraint not required to treat the resident's symptoms.
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, resident and staff interviews, facility documentation and policy review, the facility failed to implement their policy by failing to report an allegation of abuse involving 2 residents (#30 and #46) to Adult Protective Services (APS) within the required timeframe, failing to report an allegation of abuse regarding 2 residents (#229 and #56) to the State agency and APS within the required timeframe, failing to immediately put in measures to ensure further potential abuse did not occur regarding an allegation of abuse regarding 2 residents (#229 and #56), and failing to initiate an investigation when an allegation of abuse was reported involving 2 residents (#229 and #56). The deficient practice could result in notifications not be done as required, residents not being protected from further potential abuse, and allegations of abuse not being investigated. Findings include: Regarding residents #30 and #46 -Resident #30 was admitted on (MONTH) 14, (YEAR), with [DIAGNOSES REDACTED]. An incident note dated (MONTH) 30, 2019 revealed that at approximately 5:00 p.m., resident #30 and #46 were in the hallway exiting their rooms. Resident #46 was sitting in his wheelchair in front of resident #30, yelling at and trying to hit resident #30 who was trying to get away. Per the documentation, resident #46 grabbed and scratched resident #30. -Resident #46 was admitted on (MONTH) 29, (YEAR) with [DIAGNOSES REDACTED]. The alert charting note dated (MONTH) 30, 2019 revealed resident #46 was involved in a resident to resident altercation and was verbally abusive towards the other resident (#30). Review of the facility's investigative report revealed that at approximately 5:00 p.m. on (MONTH) 30, 2019, resident #30 was attempting to propel herself in her wheelchair out of her room and resident #46 was in his wheelchair propelling himself across the hallway to the side where resident #30 was attempting to leave her room. According to the report, the police interview with resident #30 revealed that both wheelchairs ran into each other. The report included a Certified Nursing Assistant (CNA) witnessed resident #46 initiate the verbal and physical aggression towards resident #30 and that resident #30 sustained a scratch to the lower left extremity that was treated by the floor nurse. The report included an interview with the CNA (staff #84) that witnessed the incident. The CNA stated resident #30 was in her wheelchair trying to come out of her room and resident #46 was trying to get through as well. Resident #46 got mad, cussed at resident #30 and tried to hit her. Per the interview, resident #30 was trying to get away when resident #46 grabbed her. The CNA stated she separated the two residents and noticed a scratch on resident #30's leg. The report included an interview with resident #46 who stated he was attempting to cross the hallway to get to the dining room door when he and resident #30 got into an altercation. The interview included resident #46 said he was upset and could not recall the rest of the incident. Continued review of the report revealed an interview with resident #30. Resident #30 stated resident #46 attacked her and scratched her leg. However, per the investigative report, the incident was not reported to APS until (MONTH) 10, 2019 at 4:33 p.m., which was 10 days after the allegation was made. An interview was conducted with the administrator (staff #111) on (MONTH) 25, 2019 at 9:52 a.m. The administrator stated the incident between resident #30 and #46 was identified as resident to resident abuse. The administrator stated the incident happened on (MONTH) 30, 2019 and was not reported to APS until (MONTH) 10, 2019. He stated the incident was not reported on time to APS and their policy was not followed. Regarding resident #56 and resident #229 -Resident #56 was admitted to the facility on (MONTH) 17, (YEAR) with [DIAGNOSES REDACTED]. -Resident #229 was admitted to the facility on (MONTH) 17, 2019 with [DIAGNOSES REDACTED]. Review of a Licensed Practical Nurse (LPN/staff #40) progress note dated (MONTH) 19, 2019 revealed resident #229 and his roommate (resident #56) were not getting along. The note included resident #229 stated his roommate threatened to have his people come and kill him tomorrow and that staff was present. The CNA stated that did not happen. The note included that this was reported to the charge nurse. The note also revealed the resident finally laid down in bed after he was reassured staff would be checking on both residents all night. However, there was no documentation that the allegation was reported to the administrator, the State agency, or APS within 2 hours of the allegation, that an investigation was initiated, or that any steps were taken to ensure residents were protected at the time of the allegation. As of (MONTH) 21, 2019, the residents involved in the altercation on (MONTH) 19, 2019 were still roommates. An interview was conducted with resident #229 on (MONTH) 21, 2019 at 11:45 a.m. Resident #229 stated his roommate (resident

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	035233	A. BUILDING _____ B. WING _____	10/25/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF GLOBE	1100 MONROE STREET GLOBE, AZ 85501

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) #56) threatened to kill him. He stated that he thought it happened on Saturday, (MONTH) 19, 2019 around dinner time as he was eating at the time. Resident #229 stated that the nurse (he was unable to identify which nurse) was with him and heard the threats made by resident #56. Resident #229 stated he was in his wheelchair with his back to the privacy curtain and that when he rolled back, he bumped into resident #56's wheelchair on the other side of the curtain. Resident #229 stated that resident #56 stated don't hit my f***ing vehicle and I'll f***ing kill you. Resident #229 stated that resident #56 also said that he would call his family to take care of him (resident #229) when resident #229 was asleep. Resident #229 stated that his nurse said that she would talk with the resident #56 and that there had been no further issues with the other resident. The allegation of resident to resident abuse that allegedly occurred on (MONTH) 19, 2019, was reported to the administrator (staff #111) by two members of the survey team on (MONTH) 21, 2019 at 1:05 p.m. The administrator stated that he did not have any knowledge of the incident between resident #56 and resident #229. Review of a room and/or roommate change notice form dated (MONTH) 21, 2019, revealed resident #229 changed rooms for the reason of safety. Review of the facility's investigative report initiated (MONTH) 21, 2019, revealed the allegation was reported to the State agency on (MONTH) 21, 2019 at approximately 1:00 p.m. and to the police department at 3:00 p.m. However, there was no documentation that a report was made to APS. An interview was conducted with a Licensed Practical Nurse (LPN/staff #40) on (MONTH) 24, 2019 at 8:43 a.m. She stated that she was the nurse caring for resident #56 and #229 on (MONTH) 19, 2019. She stated that she was notified by the CNA (staff #86) that the residents were fighting. The LPN stated that resident #229 told her that he was not going back into his room because his roommate (resident #56) said he was going to call his people and have him murdered. She stated that since resident #229 reported that resident #56 threatened him, it would be a potential abuse, and that she reported it to her charge nurse, Registered Nurse (RN/staff #115). She stated that if staff suspects, gets a report of, or witnesses a potential abuse, they are to report it to their supervisor immediately and that the supervisor/administration would do any further follow up. The LPN stated that resident #229 went back into his room after a couple of hours and that they did more frequent checks that night to make sure the residents were alright. She stated that if the residents would have had a physical altercation, she would have separated them. She said they were just arguing and people argue all of the time. The LPN stated that, as a result of staying roommates, there was a possibility that if resident #229 had continued with his behaviors, resident #56 might have struck out at him. She stated that she told the Assistant Director of Nursing (ADON/staff #72), in the morning about the incident. An interview was conducted with the CNA (staff #86) on (MONTH) 24, 2019 at 9:33 a.m. She stated that resident #56 told her that resident #229 kept running into his stuff (his vehicle and his desk) and that he did not appreciate it. She stated that resident #56 told resident #229 that If you keep f***ing doing this, I am going to f'***ing hurt you. Staff #86 stated that resident #229 stated that is a threat two times and followed her out of the room and stated that he was not going back into the room. Staff #86 stated that she let the nurse know that residents #56 and #229 were not getting along and that resident #56 told resident #229 that he would hurt him if he kept bumping into his stuff. She stated that the altercation was a potential abuse, kind of, because you should not say that to someone. She stated the expectation is for staff is to report potential abuse right away. An interview was conducted with the ADON (staff #72) on (MONTH) 24, 2019 at 10:19 a.m. She stated that she had no knowledge of the allegation of abuse between resident #229 and resident #56 that happened on (MONTH) 19, 2019 until Monday (MONTH) 21, 2019. She stated that the LPN (staff #40) had talked to her, in passing, on the morning of (MONTH) 19th or 20th about a new resident with behaviors and something taking place. She stated that she does not recall anything said that would have made her identify the situation as abuse. The ADON stated that the facility provides staff training on abuse and that staff are directed to go to the abuse officer, the administrator, or the ADON or Director of Nursing (DON) immediately if they have a potential abuse situation. She stated that the CNA may tell the immediate supervisor, but then the supervisor would be expected to call the administrator, ADON, or the DON. She stated that if the CNA witnessed a resident threatening another resident, the CNA would need to separate the residents, if needed, to make sure the residents are safe. She stated that the allegation should have been reported and investigated at the time the allegation was made and that the staff did not meet the expectation of what should be done in this situation. She stated that if the situation would have been reported to her as a threat/potential abuse, it would have triggered her to call the administrator, the DON, the Medical Director, report the allegation, start the investigation, and separate the residents. An interview was conducted with the DON (staff #12) on (MONTH) 24, 2019 at 10:40 a.m. He stated that the allegation of abuse between resident #56 and resident #229 that occurred on (MONTH) 19, 2019 was not reported to him and that he had no knowledge of the incident until (MONTH) 21, 2019. An interview was conducted with the RN (staff #115) on (MONTH) 24, 2019 at 12:04 p.m. He stated that the LPN (staff #40) told him that resident #229 was touching resident #56's bed and wheelchair and that resident #56 did not want resident #229 to do that but that resident #229 continued to do it. He stated that he delegated staff #40 to document and use secured messaging to communicate the incident to the DON and ADON. He stated that if staff #40 had told him what she documented, he would have seen it as a definite potential abuse allegation. The RN stated that the incident should have been reported and investigated at the time of occurrence. An interview was conducted with the administrator (staff #111) on (MONTH) 25, 2019 at 9:19 a.m. He stated that the staff receives training on abuse in new hire orientation, in monthly staff meetings and throughout the year. He stated that he is the abuse coordinator and that if staff suspects abuse they are to report it to him and the DON immediately. He said that a CNA may report to the nurse and the nurse may make the call to the DON but that he would still want to hear directly from the CNA who saw, suspected, or received the allegation of abuse. He stated that the CNA (staff #86) did not follow expectation/policy as she would be expected to report the incident to the DON. He stated staff should identify a threat to murder/kill/ or harm as abuse and that when the nurse (staff #40) received the report from resident #229, she should have notified the DON and/or administrator. He stated that in a resident to resident altercation, the residents need to be protected so an option to change rooms should have been presented, but was not. He stated that their policy was not followed regarding reporting, protection of residents, and investigating. Review of the facility's policy on abuse revealed that if abuse is witnessed or suspected, the resident's safety will immediately be secured. In addition, 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 definition of mental abuse included intent to threaten. The policy also included that if abuse is witnessed or suspected, reporting and investigation will take place in this manner: -The Executive Director (ED) will be notified - The ED and witness who are reporting will notify the following entities: -APS -Ombudsman -State Survey Agency -Law enforcement when applicable -Director of Nursing -Suspected abuse will be reported in accordance with timeframes and standards required by the CMS. -The ED will begin investigation immediately and complete within five days.
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 review, the facility failed to ensure an allegation of abuse involving two residents (#30 and #46) was reported to Adult Protective Services (APS) no later than two hours after the allegation was made and failed to report an allegation of abuse involving two residents (#229 and #56)

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) to the State Agency and to APS no later than two hours after the allegation was made. The deficient practice could result in allegations of abuse not being reported within the required time frame. Findings include: Regarding residents #30 and #46 -Resident #30 was admitted on (MONTH) 14, (YEAR) with [DIAGNOSES REDACTED]. -Resident #46 was admitted on (MONTH) 29, (YEAR) with [DIAGNOSES REDACTED]. Review of the facility's investigative report revealed that at approximately 5:00 p.m. on (MONTH) 30, 2019, resident #30 was attempting to propel herself in her wheelchair out of her room and resident #46 was in his wheelchair propelling himself across the hallway to the side where resident #30 was attempting to leave her room. According to the report, the police interview with resident #30 revealed that both wheelchairs ran into each other. The report included a Certified Nursing Assistant (CNA) witnessed resident #46 initiate the verbal and physical aggression towards resident #30 and that resident #30 sustained a scratch to the lower left extremity that was treated by the floor nurse. The report included an interview with the CNA (staff #84) that witnessed the incident. The CNA stated resident #30 was in her wheelchair trying to come out of her room and resident #46 was trying to get through as well. Resident #46 got mad, cussed at resident #30 and tried to hit her. Per the interview, resident #30 was trying to get away when resident #46 grabbed her. The CNA stated she separated the two residents and noticed a scratch on resident #30's leg. The report included an interview with resident #46 who stated he was attempting to cross the hallway to get to the dining room door when he and resident #30 got into an altercation. The interview included resident #46 said he was upset and could not recall the rest of the incident. Continued review of the report revealed an interview with resident #30. Resident #30 stated resident #46 attacked her and scratched her leg. However, per the investigative report, the incident was not reported to APS until (MONTH) 10, 2019 at 4:33 p.m., which was 10 days after the allegation was made. An interview was conducted with the administrator (staff #111) on (MONTH) 25, 2019 at 9:52 a.m. The administrator stated the incident between resident #30 and #46 was identified as resident to resident abuse. The administrator stated the incident happened on (MONTH) 30, 2019 and was not reported to APS until (MONTH) 10, 2019. He stated the incident was not reported on time to APS and their policy was not followed. Regarding resident #56 and resident #229: -Resident #56 was admitted to the facility on (MONTH) 17, (YEAR) with [DIAGNOSES REDACTED]. -Resident #229 was admitted to the facility on (MONTH) 17, 2019 with [DIAGNOSES REDACTED]. Review of a Licensed Practical Nurse (LPN/staff #40) progress note dated (MONTH) 19, 2019 revealed resident #229 and his roommate (resident #56) were not getting along. The note included resident #229 stated his roommate threatened to have his people come and kill him tomorrow and that staff was present. The CNA stated that did not happen. The note included that this was reported to the charge nurse. The note also revealed the resident finally laid down in bed after he was reassured staff would be checking on both residents all night. However, no documentation was found that the allegation was reported to the administrator, the State Agency or APS within the required time frame. An interview was conducted with resident #229 on (MONTH) 21, 2019 at 11:45 a.m. Resident #229 stated his roommate (resident #56) threatened to kill him. He stated that he thought it happened on Saturday, (MONTH) 19, 2019 around dinner time as he was eating at the time. Resident #229 stated that the nurse (he was unable to identify which nurse) was with him and heard the threats made by resident #56. Resident #229 stated he was in his wheelchair with his back to the privacy curtain and that when he rolled back, he bumped into resident #56's wheelchair on the other side of the curtain. Resident #229 stated that resident #56 stated don't hit my f***ing vehicle and I'll f***ing kill you. Resident #229 stated that resident #56 also said that he would call his family to take care of him (resident #229) when resident #229 was asleep. Resident #229 stated that his nurse said that she would talk with the resident #56 and that there had been no further issues with the other resident. The allegation of resident to resident abuse that allegedly occurred on (MONTH) 19, 2019, was reported to the administrator (staff #111) by two members of the survey team on (MONTH) 21, 2019 at 1:05 p.m. The administrator stated that he did not have any knowledge of the incident between resident #56 and resident #229. Review of the facility's investigative report initiated (MONTH) 21, 2019, revealed the allegation was reported to the State agency on (MONTH) 21, 2019 at approximately 1:00 p.m. and to the police department at 3:00 p.m. However, there was no documentation that a report was made to APS. An interview was conducted with a Licensed Practical Nurse (LPN/staff #40) on (MONTH) 24, 2019 at 8:43 a.m. The LPN stated that on (MONTH) 19, 2019, she was notified by the CNA (staff #86) that the resident #229 and resident #56 were fighting. She stated that resident #229 told her that he was not going back into his room because his roommate, resident #56 said he was going to call his people and have him murdered. She stated that reported the abuse allegation to her charge nurse, Registered Nurse (RN/staff #115). She stated that if staff suspects, gets a report of, or witnesses a potential abuse they are to report to their supervisor immediately and that the supervisor/administration would do any further follow up. The LPN also stated that she told the Assistant Director of Nursing (ADON/staff #72), in the morning about the incident. An interview was conducted with the CNA (staff #86) on (MONTH) 24, 2019 at 9:33 a.m. She stated that resident #56 told her that resident #229 kept running into his stuff (his vehicle and his desk) and that he did not appreciate it. She stated that resident #56 told resident #229 that If you keep f***ing doing this, I am going to f'***ing hurt you. Staff #86 stated that resident #229 stated that is a threat two times and followed her out of the room and stated that he was not going back into the room. Staff #86 stated that she let the nurse know that residents #56 and #229 were not getting along and that resident #56 told resident #229 that he would hurt him if he kept bumping into his stuff. She stated that the altercation was a potential abuse, kind of, because you should not say that to someone. She stated the expectation is for staff is to report potential abuse right away. An interview was conducted with the ADON (staff #72) on (MONTH) 24, 2019 at 10:19 a.m. She stated that she had no knowledge of the allegation of abuse between resident #229 and resident #56 that happened on (MONTH) 19, 2019 until Monday (MONTH) 21, 2019. She stated that the LPN (staff #40) had talked to her, in passing, on the morning of (MONTH) 19th or 20th about a new resident with behaviors and something taking place. She stated that she does not recall anything said that would have made her identify the situation as abuse. The ADON stated that staff are to report to the abuse officer, the administrator, or the ADON or Director of Nursing (DON) immediately if they have a potential abuse situation. She stated that the CNA may tell the immediate supervisor, but then the supervisor would be expected to call the administrator, ADON, or the DON. She stated that the allegation should have been reported at the time the allegation was made. She stated that if the situation would have been reported to her as a threat/potential abuse, it would have triggered her to call the administrator, the DON, the Medical Director to report the allegation. An interview was conducted with the DON (staff #12) on (MONTH) 24, 2019 at 10:40 a.m. He stated that the allegation of abuse between resident #56 and resident #229 that occurred on (MONTH) 19, 2019 was not reported to him and that he had no knowledge of the incident until (MONTH) 21, 2019. An interview was conducted with the administrator (staff #111) on (MONTH) 25, 2019 at 9:19 a.m. He stated that he is the abuse coordinator and that if staff suspects abuse they are to report it to him and the DON immediately. He said that a CNA may report to the nurse and the nurse may make the call to the DON but that he would still want to hear directly from the CNA who saw, suspected, or received the allegation of abuse. He stated staff should identify a threat to murder/kill/ or harm as abuse and that when the nurse (staff #40) received the report from resident #229, she should have notified the DON and/or administrator. Review of the facility's policy on abuse revealed that if abuse is witnessed or suspected, prompt reporting will occur and will take place in this manner: -The Executive Director (ED) will be notified -The ED and witness who are reporting will notify to following entities: -APS -Ombudsman -State Survey Agency

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) -Law enforcement when applicable -Director of Nursing -Suspected abuse will be reported in accordance with timeframes and standards required by the CMS.
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 review, staff interviews, and policy review, the facility failed to initiate an investigation and prevent further potential abuse when one resident (#229) reported an allegation of abuse involving resident #56. The deficient practice could result in further potential abuse. -Resident #56 was admitted to the facility on (MONTH) 17, (YEAR) with [DIAGNOSES REDACTED]. -Resident #229 was admitted to the facility on (MONTH) 17, 2019 with [DIAGNOSES REDACTED]. Review of a Licensed Practical Nurse (LPN/staff #40) progress note dated (MONTH) 19, 2019 revealed resident #229 and his roommate (resident #56) were not getting along. The note included resident #229 stated his roommate threatened to have his people come and kill him tomorrow and that staff was present. The CNA stated that did not happen. The note included that this was reported to the charge nurse. The note also revealed the resident finally laid down in bed after he was reassured staff would be checking on both residents all night. However, no documentation was found that an investigation was initiated or that measures were put in place to ensure further potential abuse did not occur. As of (MONTH) 21, 2019, the residents involved in the altercation on (MONTH) 19, 2019 were still roommates. Review of the facility's investigative report initiated (MONTH) 21, 2019, revealed that on (MONTH) 19, 2019 at approximately 7:00 p.m., resident #229 told staff that he wanted to be moved to a private room because he was threatened by his roommate (resident #56). The report also revealed management found out about the incident on (MONTH) 21, 2019. The report included that on (MONTH) 21, 2019, resident #229 was moved to another room and an investigation was initiated. Review of a room and/or roommate change notice form dated (MONTH) 21, 2019, revealed resident #229 changed rooms for the reason of safety. An interview was conducted with the Licensed Practical Nurse (LPN/staff #40) on (MONTH) 24, 2019 at 8:43 a.m. She stated that resident #229 told her that he was not going back into his room again because his roommate, resident #56 said he was going to call his people and have him murdered. She stated that if staff suspects, gets a report of, or witnesses a potential abuse they are to report to their supervisor immediately and that the supervisor/administration would do any further follow up. The LPN stated that resident #229 went back into his room after a couple of hours and that they did more frequent checks that night to make sure the residents were alright. She stated that if the residents would have had a physical altercation, she would have separated them. She said they were just arguing and people argue all of the time. The LPN stated that, as a result of staying roommates, there was a possibility that if resident #229 had continued with his behaviors, resident #56 might have struck out at him. An interview was conducted with the Assistant Director of Nursing (staff #72) on (MONTH) 24, 2019 at 10:19 a.m. She stated that she had no knowledge of the allegation of abuse between resident #229 and resident #56 that happened on (MONTH) 19, 2019 until Monday (MONTH) 21, 2019. She stated that if a CNA witnessed a resident threatening another resident, the CNA would need to separate the residents, if needed, to make sure the residents are safe. She stated that the allegation should have been investigated at the time the allegation was made. She stated that if the situation would have been reported to her as a threat/potential abuse it would have triggered her to start the investigation and separate the residents. An interview was conducted with the administrator (staff #111) on (MONTH) 25, 2019 at 9:19 a.m. He stated that in a resident to resident altercation, the residents need to be protected so an option to change rooms should have been presented, but was not. He stated that their policy was not followed regarding protection of residents and investigating. Review of the facility's policy on abuse revealed that if abuse is witnessed or suspected, the resident's safety will immediately be secured. In addition, 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 that if abuse is witnessed or suspected, the Executive Director will begin investigation immediately.
F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, and policy review, the facility failed to ensure 2 of 5 sampled residents (#129 and #17) were free of unnecessary drugs, by failing to administer medications within the physician ordered parameters. The deficient practice could result in residents receiving medications that may not be necessary. Findings include: -Resident #129 was admitted on (MONTH) 16, 2019, with [DIAGNOSES REDACTED]. Review of the care plan dated (MONTH) 17, 2019 revealed the resident had hypertension related to lifestyle. The goal was the resident will be free from complications related to hypertension. Interventions included giving antihypertensive medications as ordered, obtaining blood pressure readings per orders and as needed, and reporting to the physician as necessary. Regarding [MEDICATION NAME] (antihypertensive) The physician order [REDACTED].<60. This order was transcribed onto the MAR (medication administration record) and was administered as ordered from (MONTH) 18 through 30, 2019. This order continued to be transcribed onto the MAR for (MONTH) 2019. However, the documentation on the MAR for (MONTH) 2019 revealed [MEDICATION NAME] was administered outside of the ordered parameters on the following dates: -October 5 for SBP of 105; -October 14 for HR of 53; and, -October 21 for HR of 54 Regarding [MEDICATION NAME] (antihypertensive) A physician order [REDACTED]. This order was transcribed onto the MAR for (MONTH) 2019. According to the documentation on the MAR for (MONTH) 2019, [MEDICATION NAME] was administered outside of the ordered parameter on the following dates: -October 14 for pulse of 53; -October 16 for pulse of 58; -October 19 for pulse of 57; and, -October 21 for pulse of 54 Regarding [MEDICATION NAME] (antihypertensive) A physician order [REDACTED].<120 or HR of <60. This order was transcribed onto the MAR for (MONTH) 2019. Review of the MAR for (MONTH) revealed [MEDICATION NAME] was administered outside of the ordered parameter on the following dates: -October 21 for pulse of 58 -October 22 for pulse of 58 Review of the clinical record revealed no documentation why these medications were administered to the resident outside of the physician ordered parameters. An interview was conducted with a licensed practical nurse (LPN/staff #8) on (MONTH) 25, 2019 at 8:47 a.m. He said all medications are administered following the parameters as ordered by the physician. He also said if the resident's values such as blood pressure or pulse rate are outside the ordered parameters, he will not give the medication and will call the physician for further direction. He said if the physician instructed him to give the medication despite the values being outside of the ordered parameters, he will administer the medication and document in the progress note that the physician was notified and had given him the instruction to give the medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035233	A. BUILDING _____ B. WING _____	**10/25/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF GLOBE	**1100 MONROE STREET GLOBE, AZ 85501**

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 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 7) During an interview conducted with another LPN (staff #66) on (MONTH) 25, 2019 at 9:50 a.m., he stated medications are administered following the ordered parameters. The LPN said if the resident's values are outside of the ordered parameters, he will not give the medication, will call the physician and will document in the electronic record why the medication was not given. In an interview with the Director of Nursing (DON/staff #12) conducted on (MONTH) 25, 2019 at 10:22 a.m., he stated the nurses are expected to follow the physician orders [REDACTED]. He stated that if the resident's values are outside of the ordered parameters, the nurses are expected hold the medications, notify the physician and document in the electronic record why the medication was not given. -Resident #17 was admitted on (MONTH) 24, 2019, with [DIAGNOSES REDACTED]. Review of the clinical record revealed a physician order [REDACTED]. According to a quarterly Minimum Data Set assessment dated (MONTH) 31, 2019, the resident had a Brief Interview for Mental Status score of 10, indicating the resident had moderate impaired cognition. A review of the MAR for (MONTH) 2019 revealed [MEDICATION NAME]-[MEDICATION NAME] was administered for the following pain levels: August 1, AM shift, for pain level of 6 August 15, PM shift, for pain level of 6 August 19, AM shift, for pain level of 6 August 22, AM shift, for pain level of 2; and PM shift, for pain level of 2 August 29, AM shift, for pain level of 6 August 31, AM shift, for pain level of 6 Review of the MAR indicated [REDACTED] September 2, AM shift, for pain level of 6 September 3, AM shift, for pain level of 6; and PM shift, for pain level of 5 September 10, AM shift, for pain level of 5 September 13, AM shift, for pain level of 5 September 25, AM shift, for pain level of 5 September 29, AM shift, for pain level of 6; and PM shift, for pain level of 4 September 30, AM shift, for pain level of 6 Review of the clinical record revealed the order for [MEDICATION NAME]-[MEDICATION NAME] was discontinued (MONTH) 3, 2019. Continued review of the clinical record revealed a physician order [REDACTED]. Review of the MAR for (MONTH) 2019 revealed [MEDICATION NAME] was administered on 6 occasions when the resident's reported pain level was not within the ordered parameters: October 9, AM shift, for pain level of 5 October 10, AM shift, for pain level of 1 October 12, AM shift, for pain level of 6 October 14, AM shift, for pain level of 5 October 16, AM shift, for pain level of 6 October 20, PM shift, for pain level of 6 Review of the nursing notes for August, September, and (MONTH) 2019, revealed no evidence why the medications were administered outside of the physician ordered parameters. An interview was conducted with a Registered Nurse (RN/staff #118) on (MONTH) 24, 2019 at 10:01 a.m. She stated when administering medications, she would follow the physician's orders [REDACTED]. The RN stated that if the resident's pain level is not within the ordered parameters for the medication, she would try non-pharmacological interventions, or see if there was an order for [REDACTED]. Staff #118 reviewed the MAR for resident #17 and stated the medication did appear to be given several times when the resident's pain level was less than the parameters in the order. An interview was conducted with the DON (staff #12) on (MONTH) 24, 2019 at 10:29 a. m. He stated his expectation is for the nurses to administer all medication as ordered, including following any parameters. The DON stated that if there is a reason for the medication to be administered other than as ordered, there should be a note documenting the reason. The DON said if there is a resident who is regularly requesting pain medication outside of the ordered parameters, he and the nurse would follow up with the physician and document that. After reviewing resident #17's clinical record, the DON stated the nurse should not have administered the medication for the pain levels under 7. He said there should be an order for [REDACTED].>A facility's policy titled Administering Medications revised (MONTH) 2012, revealed medications shall be administered in a safe and timely manner, and as prescribed, and that medications must be administered in accordance with the orders.