STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035277**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/27/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF LAKESIDE	**3401 NORTH LOCKWOOD DRIVE LAKESIDE, AZ 85929**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0578

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure one sampled resident's (#53) advanced directive was consistent in the clinical record. The census was 89. This deficient practice could result in residents not receiving emergent services, which are not in accordance with their wishes.
Findings include:
Resident #53 was admitted to the facility on (MONTH) 15, 2019, with [DIAGNOSES REDACTED].
Review of the clinical record revealed a nurse practitioner progress note dated (MONTH) 16, 2019, that advance directives were discussed in detail with the resident and that the resident desired all available measures.
Review of the clinical record also revealed a Pre-Hospital Medical Care Directive (Do Not Resuscitate) document obtained from the resident's representative via telephone dated (MONTH) 17, 2019.
Continued review of the clinical record revealed a Social Service Admission assessment dated (MONTH) 22, 2019 that the resident was a full code.
Further review of the clinical record revealed an Advanced Directive form with a signature by the space for the resident's signature dated (MONTH) 29, 2019, that the resident's choice was for cardiopulmonary resuscitation (full code).
Additional review of the clinical record revealed a physician order [REDACTED].
During an interview conducted with the resident on (MONTH) 27, 2019 at 10:35 a.m., the resident stated that she wanted CPR performed if she was to code.
An interview was conducted with the Assistant Director of Nursing (staff #84) on (MONTH) 27, 2019 at 10:36 a.m. She stated that when a resident is admitted , an Advanced Directive Form is completed. Staff #84 stated that the Advanced Directive Form dated (MONTH) 29, 2019 for resident #53 indicated the resident is a full code. She also stated that the Do Not Resuscitate document dated (MONTH) 17, 2019 was no longer in effect. She further stated that she was unsure why the physician's orders [REDACTED]. She stated that it was clearly an error.
During an interview conducted with the Director of Nursing (DON/staff #10) on (MONTH) 27, 2019 at 10:47 a.m., she stated that there were multiple entries in resident's #53 clinical record for full code and do not resuscitate. The DON stated that the Do Not Resuscitate document was no longer valid since the resident had completed an Advance Directive form. She also stated that the confusion regarding the resident's advance directive is most likely due to having both the Do Not Resuscitate and the Advanced Directive form in the resident's clinical record.
The facility's policy regarding Advanced Directives revealed advanced directives will be respected in accordance with state law and facility policy and that the plan of care for each resident will be consistent with his or her documented treatment preferences and/or advanced directive.

F 0641

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident receives an accurate assessment.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on clinical record review, staff interviews, policy review, and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure a Minimum Data Set (MDS) assessment was accurate for one sampled resident (#43). This deficient practice could result in care plans not accurately reflecting the resident's status and could affect residents' continuity of care.
Findings include:
Resident #43 was admitted to the facility on (MONTH) 19, (YEAR) with [DIAGNOSES REDACTED].
Review of the admission MDS assessment dated (MONTH) 26, (YEAR) revealed no evidence the resident had been assessed for cognitive patterns.
Further review of the assessment revealed the resident was not assessed for activities and preferences for customary routine.
An interview was conducted with the Activities Director (staff #29) on (MONTH) 27, 2019 at 10:00 a.m. Staff #29 stated that she conducts an activity assessment to develop the activity plan for a resident when they are admitted . She stated that when a resident is unable to do the activity assessment, she would call the family. She stated that if the family did not call back then she would be unable to do the activity assessment and that she would not do the staff assessment. Staff #29 acknowledged that this resident was not assessed for activities on the comprehensive MDS assessment.
An interview was conducted with the Registered Nurse MDS Coordinator (RN/staff #36) on (MONTH) 27, 2019 at 11:16 a.m. She stated the expectation is that the MDS assessments be accurate and complete. She stated that she uses the RAI manual for direction when completing the MDS assessments. After reviewing the assessment for resident #43, she stated that activities were not assessed for the resident.
An interview was conducted with the Executive Director (staff #112) on (MONTH) 27, 2019 at 11:00 a.m. He stated that activities should be assessed for every resident regardless of their ability to participate in the activity assessment process. Staff #112 stated that he does think it is appropriate for the MDS assessment activity section to be documented as not assessed. He stated that if the resident was unable to be interviewed, then the staff assessment should be completed.
The RAI manual revealed cognitive patterns are assessed to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions. Attempt to conduct the interview with all residents.
The manual also revealed obtaining information regarding the resident's preferences for his or her daily routine and activities should be used as a guide to create an individualized plan based on the resident's preferences. This is best accomplished when the information is obtained directly from the resident or through family or significant other, or staff interviews if the resident cannot report preferences. Attempt to conduct the interview with all residents.
The manual included that the importance of accurately completing and submitting the MDS assessment cannot be over emphasized. The manual also included that the MDS assessment is the basis for the development of an individualized care plan.
Review of the facility's policy for Activity Assessment revealed that in order to promote the physical, mental and psychosocial well-being of residents, an activity assessment is conducted and maintained for each resident. The policy included that within 14 days of a resident's admission to the facility, an activity assessment will be conducted to help

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 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) develop an activities plan that reflects the choices and interests of the resident. The policy also included that the resident's activity assessment is conducted by the activity staff in conjunction with other staff who will assess related factors such as functional level, cognition, and medical conditions that may affect activities participation. The policy included the resident's lifelong interests, spirituality, life roles, goals, strengths, needs and activity pursuit patterns and preferences will be included in the assessment.
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure that a comprehensive person-centered care plan was developed regarding activities for one sampled resident (#43). The deficient practice could result in the resident not being provided activities consistent with the resident's choice and abilities. The census was 89. Findings include: Resident #43 was admitted to the facility on (MONTH) 19, (YEAR), with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 26, (YEAR), revealed the resident had minimal difficulty in hearing and highly impaired vision and that communication would be addressed in the care plan. The assessment also revealed the resident was not assessed for activities and preferences for customary routine. The Activity Care Area Assessment (CAA) included the resident was at risk for decreased activities and socialization. Review of the care dated (MONTH) 8, (YEAR) regarding recreational interests/patterns included the resident had daily contact with close friends and/or family, was involved in group activities such as arts and crafts, and spent most of his time alone or watching TV. The intervention was encouraging the family to bring books, newspapers, and magazines for the resident to read. Further review of the recreational care plan revealed the resident's altered communication was not addressed. During an interview conducted with the resident on (MONTH) 25, 2019 at 12:42 p.m., the resident stated that he could not see or hear. The resident was observed sitting in the wheelchair in his room without any activity occurring. There was no music playing and the television was off. During an interview conducted with a Certified Nursing Assistant (staff #22) on (MONTH) 27, 2019 at 9:37 a.m., staff #22 stated that the resident sleeps a lot. She stated that the resident may have had 2-3 visitors in the last 6 months. On (MONTH) 27, 2019 at 9:47 a.m., an interview was conducted with a Licensed Practical Nurse (LPN/staff #16). The LPN stated that she has offered to turn the television on for resident #43 and that he replied why, can't see anyway. She stated that in the last 6 months, she had only seen a family member visit a couple of times. On (MONTH) 27, 2019 at 10:00 a.m., an interview was conducted with the Activities Director (staff #29). After reviewing the recreational care plan, she stated that the care plan was not appropriate for the resident. Staff #29 stated that the resident does not have daily contact with close friends or family, is unable to participate in arts and crafts, and is unable to read the provided materials related to impaired vision/[MEDICAL CONDITION]. An interview was conducted with the Executive Director (staff #112) on (MONTH) 27, 2019 at 11:00 a.m. He stated the expectation is that the care plan reflects the resident's abilities and interests. After reviewing the resident's care plan, he stated that the recreational care plan was not appropriate for the resident because of the resident's impairment in vision and hearing. An interview was conducted with the Registered Nurse MDS Coordinator (RN/staff #36) on (MONTH) 27, 2019 at 11:16 a.m. She stated that the recreational care plan did not reflect the resident's hearing and vision deficits. Review of the facility's policy regarding comprehensive care plans revealed an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. The policy included each resident's comprehensive care plan is designed to incorporate identified problem areas, incorporate risk factors associated with the identified problems, build on the resident's strengths, and reflect currently recognized standards of practice for problem areas and conditions. The facility's policy titled Activity Assessment included the activity assessment is used to develop an individual activities care plan that will allow the resident to participate in activities of his/her choice and interest. Each resident's activities care plan shall relate to his/her comprehensive assessment and shall reflect his/her individual needs. The policy included the activity assessment and activities care plan will identify if a resident is capable of pursuing activities without intervention from the facility. The facility's policy for activities and social services revealed that as much as possible, activities, social events, and schedules will be provided that are compatible with the resident's interests, physical and mental assessment, and overall plan of care.
F 0679 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews, and policy and procedure, the facility failed to provide an ongoing resident centered activities program based on the comprehensive assessment, care plan, and the resident's preferences for one sampled resident (#43). The deficient practice could result in the resident not participating in activities. The census was 89. Findings include: Resident #43 was admitted to the facility on (MONTH) 19, (YEAR) with [DIAGNOSES REDACTED]. Review of the Activity Data Collection form dated (MONTH) 26, (YEAR) revealed the resident was not assessed and the form was incomplete. The admission Minimum Data Set (MDS) assessment dated (MONTH) 26, (YEAR) revealed the resident had minimal difficulty in hearing and highly impaired vision. The assessment included the resident was able to make himself understood and understood others. The section for activities and preferences for customary routine was not completed. The Activity Care Area Assessment (CAA) included the resident was at risk for decreased activities and socialization. Review of the vision care plan dated (MONTH) 19, (YEAR) revealed the resident had impaired visual function related to being legally blind. The goal was that the resident would maintain optimal quality of life within limitation imposed by visual function. Review of the care plan dated (MONTH) 8, (YEAR) regarding recreational interests/patterns included the resident had daily contact with close friends and/or family, was involved in group activities such as arts and crafts and spent most of his time alone or watching TV. The intervention was encouraging the family to bring books, newspapers, and magazines for the resident to read. The recreational care plan did not include the resident's altered communication regarding vision and hearing. Review of the activities daily documentation in the electronic record for (MONTH) 26, (YEAR) through (MONTH) 17, 2019, revealed documentation the resident actively participated with activities of movie, television, and music. Review of the activities daily documentation for (MONTH) 18, 2019 through (MONTH) 27, 2019 revealed no activities for the resident. Observations were conducted of the resident on (MONTH) 25, 2019. At 12:42 p.m., the resident was observed sitting in the wheelchair in his room without any activity occurring. There was no music playing and the television was off. At 2:02 p.m., the resident appeared to be sleeping in bed. During observations conducted of the resident on (MONTH) 26, 2019, the resident appeared to be sleeping in bed at 11:00 a.m. and 1:51 a.m. At 1130 a.m., the resident was taken to the dining room in the wheelchair. The resident was observed in conversation with staff. Observations were conducted of the resident on (MONTH) 27, 2019. At 7:34 a.m., the resident was observed in the dining room for breakfast. At 9:31 a.m., the resident appeared to be sleeping in bed with earphones on that were attached to an audio player.

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F 0679 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) During an interview conducted with the resident on (MONTH) 25, 2019 at 12:42 p.m., the resident stated that he could not see or hear. An interview was conducted with a Certified Nursing Assistant (CNA/staff #22) on (MONTH) 27, 2019 at 9:37 a.m. She stated that resident #43 likes to talk about the war and watch western movies. The CNA stated that about a month ago the Activities Director started giving him books on tape to listen to with headphones. She stated that she has invited him to activities but that he usually refuses because he wants to lie down after meals. The CNA stated that family and/or friends do not visit often. She stated that the resident may have had 2-3 visitors in the last 6 months. The CNA also stated that there was no place for her to document the resident's activities or refusal of activities. An interview was conducted with a Licensed Practical Nurse (LPN/staff #16) on (MONTH) 27, 2019 at 9:47 a.m. She stated that they try to get the resident to participate in activities but the resident wants to go to bed. She stated that the resident likes the audio books. The LPN stated that she has offered to turn the television on for resident #43 and that he replied why, can't see anyway. She stated that in the last 6 months, she had only seen a family member visit a couple of times. The LPN also stated that she does not document the resident's activities. An interview was conducted with the Activities Director (staff #29) on (MONTH) 27, 2019 at 10:00 a.m. She stated that to develop an activity plan for a resident she does an activity assessment for each resident upon admission to find out what kind of activities the resident likes. Staff #29 stated that at the care plan meetings she asks about activities the resident liked to do when they were home. She acknowledged resident #43 was not assessed for activities on the comprehensive MDS assessment. She stated that about a month ago she got the resident involved with the listening library and he loves it. After reviewing the recreational care plan, she stated that the care plan was not appropriate for the resident. Staff #29 stated that the resident does not have daily contact with close friends or family, is unable to participate in arts and crafts, and is unable to read provided materials related to impaired vision/[MEDICAL CONDITION]. She stated that the expectation is that her assessments and care plans be complete and accurate. Staff #29 stated that the only place to document whether the resident participated in an activity or refused an activity is in the electronic record. She also stated that she had no additional documentation of this resident's activity participation or refusals. During an interview conducted with the activities assistant (staff #3) on (MONTH) 27, 2019 at 10:54 a.m., she stated that the resident does not want to go to any group activities. Staff #3 stated that about a month ago, the resident started listening to audio books. She also stated that she offers him snacks and coffee. Staff #3 stated there was nowhere for her to document whether the resident attended an activity or refused an activity. An interview was conducted with the Executive Director (staff #112) on (MONTH) 27, 2019 at 11:00 a.m. He stated that the expectation is that staff find out the resident's capabilities in regards to activities. He also stated the expectation is that there be documentation of the activities provided to the resident and documentation of activities the resident refused. Staff #112 stated that the activity staff should have an understanding of what the resident can and cannot do and what the resident was interested in doing. Review of the facility's policy for Activity Assessment revealed that in order to promote the physical, mental and psychosocial well-being of residents, an activity assessment is conducted and maintained for each resident. The policy included that within 14 days of a resident's admission to the facility, an activity assessment will be conducted to help develop an activities plan that reflects the choices and interests of the resident. The policy also included that the resident's activity assessment is conducted by the activity staff in conjunction with other staff who will assess related factors such as functional level, cognition, and medical conditions that may affect activities participation. The policy included the resident's lifelong interests, spirituality, life roles, goals, strengths, needs and activity pursuit patterns and preferences will be included in the assessment. The facility's policy for activities and social services revealed that as much as possible, activities, social events, and schedules will be provided that are compatible with the resident's interests, physical and mental assessment, and overall plan of care. The policy included the residents have the right to choose the types of activities and social events in which they wish to participate. The policy also included the Interdisciplinary Care Team will evaluate the resident's personal history and preference, and will consider medical condition and prognosis in identifying relevant recreational and cultural activities.