STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035240	A. BUILDING _____ B. WING _____	10/30/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF LAKE HAVASU	2781 OSBORNE DRIVE LAKE HAVASU CITY, AZ 86406

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record review, staff interviews, facility documentation and policies and procedures, the facility failed to ensure that one of two sampled residents (#35) was free from verbal abuse by a staff member. The deficient practice could result in further incidents of abuse. Findings include: Resident #35 was admitted on (MONTH) 22, 2019 with [DIAGNOSES REDACTED]. A written care plan dated (MONTH) 22, 2019 identified that the resident had a communication deficit related to [DIAGNOSES REDACTED]. The care plan included the resident was deaf in the left ear and was 90% deaf in the right ear. As a result, the resident must communicate with a white board or speak loudly face to face. An intervention was to ensure availability and functioning of adaptive communication equipment. A care plan for cognitive function/dementia or impaired thought processes and communicating secondary to hearing deficits which was initiated on (MONTH) 27, 2019, revealed the following interventions: Communicate with resident using white boards/communication boards to ensure understanding; provide a homelike environment; and use task segmentation to support short term memory deficits. A quarterly MDS (Minimum Data Set) assessment dated (MONTH) 29, 2019 included the resident had a BIMS (Brief Interview for Mental Status) score of 9, which indicated moderate cognitive impairment. The MDS also included the resident had highly impaired hearing, had clear comprehension of others and was able to make himself understood. Review of the facility's investigative report revealed that on (MONTH) 3, 2019 at 5:50 a.m., a Registered Nurse (RN/staff #8) witnessed a licensed nursing assistant (LNA/staff #71) yelling at resident #35. The incident took place in a common area. Per the report, staff #71 was continuously arguing and screaming loud at resident #35. Staff #8 told staff #71 to stop and get away from the resident, but staff #71 stated no and told her to back him up. The report included an interview with staff #71, who reported that the resident was getting all of the coffee creamers so he told him to stop, but he kept getting into them. Staff #71 reported that the resident was very hard of hearing and he was speaking loudly to him and the nurse told him to stop and he was upset with the nurse for not backing him up. He denied yelling at the resident. The report further included that a total of three staff witnessed the incident and all reported the same thing. Per the report, verbal abuse was substantiated based on witness statements and interviews, and staff #71 was terminated. Review of the personnel records for staff #71 revealed an Employee Disciplinary form dated (MONTH) 12, 2019, which included that the actions of staff #71 resulted in substantiated verbal abuse against a resident; that staff #71 had also refused to follow instructions from a nursing supervisor regarding his actions related to the incident; and that his employment had been terminated. During an interview conducted on (MONTH) 29, 2019 at 12:54 p.m. with staff #8, she stated that on the morning of (MONTH) 3, 2019 while she was providing care to a resident near the common area, she heard staff #71 yelling and screaming at a resident (#35) he was angry and mean and loud, and that the resident was really upset and yelling at staff #71. Staff #8 stated that she told staff #71 to stop yelling and he ignored her, and when she finished providing care to the other resident, she told staff #71 again to stop yelling at resident #35 and staff #71 continued to ignore her, and continued to yell at the resident. Staff #8 stated that she thought it was verbal abuse. During an interview conducted on (MONTH) 30, 2019 at 10:00 a.m. with the Administrator (staff #74), he stated there were staff witnesses who said that staff #71 was yelling at the resident in a manner that was construed as abuse. He said that abuse was substantiated because it fit their policy definition of abuse, and that was why staff #71 was terminated. The Administrator stated that a plan of correction regarding the substantiated allegation of abuse had been initiated as part of the facility's QAPI (Quality Assurance Performance Improvement) program. He said the program included audits and in-service education regarding abuse which has been provided to all staff, and will continue to be provided to staff each month. Review of the facility's QAPI Plan of Correction revealed the following plan: -Training regarding abuse will be provided monthly (instead of annually). -Training will include specific examples, and will be written and verbal. -The contact numbers for reporting abuse allegations will be posted at the time clock. -Staff will be encouraged to speak with Administration members for any questions they may have about proper reporting. -Progress will be followed up by the QAPI committee and continually discussed for any modifications. -Weekly auditing of all reportable events was initiated on (MONTH) 12, 2019 and was on-going at the time of the recertification survey. Review of the QAPI Audits revealed that audits were done weekly from (MONTH) 2019 through (MONTH) 2019 regarding allegations of abuse. In addition, the in-service records revealed that in-services for all staff members regarding abuse, reporting abuse and resident rights were provided in August, (MONTH) and (MONTH) 2019. Review of a staff in-service titled, Resident Rights and Abuse revealed Our facility does not condone resident abuse by anyone including staff members. By definition, abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Verbal abuse is the use of oral, written or gestured language, regardless of the resident's ability to understand what has been said or done, and includes yelling, belittling, intimidating and using derogatory terms. Review of the Abuse policy revealed that abuse is the infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, and that instances of abuse, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. The policy included that abuse includes verbal and that potential abusers can be employees.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record reviews, staff interviews, facility documentation, review of the State Agency data base and policies and procedures, the facility failed to implement their Abuse policies and procedures, by staff failing to immediately report two allegations of abuse involving two sampled residents (#35 and #51) to the Administrator and report the allegations to the State Agency and Adult Protective Services (APS) within two hours after the allegations were made,

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

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) by failing to initiate two abuse investigations timely and by failing to protect residents from the potential for further abuse. The deficient practice could result in allegations of abuse not being investigated timely causing a delay in corrective action being implemented and subjecting residents to the potential for further abuse. Findings include: Regarding resident #51 and staff #71: -Resident #51 was admitted on (MONTH) 23, 2019 with [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set) assessment dated (MONTH) 30, 2019 included the resident had a BIMS (Brief Interview for Mental Status) score of 15, which indicated intact cognition. Review of a facility's investigative report revealed that on (MONTH) 2, 2019 at 8:50 p.m., resident #51 told a RN (Registered Nurse/staff #72) that a LNA (Licensed Nursing Assistant/staff #71) had told him that he didn't need his pills and to shut up and go back to sleep. The report included the resident had asked staff #71 to tell the nurse that he was ready for more pain medication and that staff #71 yelled at him and told him You don't need any pills so shut up and go back to sleep. The report included the allegation was unsubstantiated as there were no witnesses. Per the report, staff #72 thought the incident would be verbal abuse and thought about calling, but she wasn't sure so she left a note in the Administrators mailbox instead. The report further included the following: the allegation of abuse was not reported to the State Agency and APS until (MONTH) 5, 2019; an investigation was not initiated until (MONTH) 5, 2019; and staff #71 was not removed from providing care to residents until (MONTH) 5, 2019. Review of the State Agency data base revealed that although the events described in the facility's investigation occurred on (MONTH) 2, 2019 at 8:50 p.m., the allegation of abuse was not reported to the State Agency and APS until (MONTH) 5, 2019 at 7:43 p.m. During an interview conducted on (MONTH) 29, 2019 at 12:18 p.m. with a RN (staff #72), she stated that early on the night shift (on (MONTH) 2, 2019), she responded to a call light for resident #51. She said the resident told her that staff #71 had told him to shut up and go to bed. Staff #72 stated that she did not report the allegation of abuse, because she had not witnessed it happening, and assumed that she had to witness abuse to report it. She said that she assumed the charge nurse (RN/staff #8) had notified the Administrator. Staff #72 stated that she or the charge nurse (staff #8) could have reported the allegation to the Administrator. She said that although she did ask staff #71 not to enter resident #51's room for the rest of the night shift, she did not remember if he had continued to provide care to residents for the remainder of his shift, or if he had finished his shift. Staff #72 stated that staff #71 should have probably been sent home. When asked how she ensured that resident's were protected from the potential for further abuse after the allegation was made that night, she said that she did not know. During an interview conducted on (MONTH) 29, 2019 at 12:54 p.m. with the Charge Nurse (RN/staff #8), she stated that early on the night shift on (MONTH) 2, 2019, staff #72 told her that resident #51 had said that staff #71 told him to shut up. Staff #8 stated she asked staff #72 to write a statement, which she put in the Administrator's office. Staff #8 said the event occurred on the weekend and the Administrator's office was closed. Regarding resident #35 and staff #71: -Resident #35 was admitted on (MONTH) 22, 2019 with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 29, 2019 included the resident had a BIMS score of 9, which indicated moderate cognitive impairment. The MDS also included the resident had highly impaired hearing, had clear comprehension of others and was able to make himself understood. Review of the facility's investigative report revealed that on (MONTH) 3, 2019 at 5:50 a.m., a Registered Nurse (RN/staff #8) witnessed a licensed nursing assistant (LNA/staff #71) yelling at resident #35. The incident took place in a common area. Per the report, staff #71 was continuously arguing and screaming loud at resident #35. Staff #8 told staff #71 to stop and get away from the resident, but staff #71 stated no and told her to back him up. The report included an interview with staff #71, who reported the resident was getting all of the coffee creamers so he told him to stop, but he kept getting into them. Staff #71 reported that the resident was very hard of hearing and he was speaking loudly to him and the nurse told him to stop and he was upset with the nurse for not backing him up. He denied yelling at the resident. The report included that a total of three staff witnessed the incident and all reported the same thing. Per the report, verbal abuse was substantiated based on witness statements and interviews, and staff #71 was terminated. The report further included that staff #71 was not removed from providing care to residents until (MONTH) 5, 2019, and that an investigation was not initiated until (MONTH) 5. The report further included that the allegation of abuse was not reported to the State Agency and APS until (MONTH) 5, 2019 at 7:30 p.m. The report also stated that verbal abuse was substantiated based on witness statements and interviews, and staff #71 was terminated. Review of the State Agency data base revealed that although the events described in the facility's investigation occurred on (MONTH) 3, 2019 at 5:50 a.m., it was not reported to the State Agency and APS until (MONTH) 5, 2019 at 7:43 p.m. In an interview conducted on (MONTH) 29, 2019 at 12:54 p.m. with staff #8, she stated that later on that same night shift (early in the morning on (MONTH) 3, 2019), she was providing care to a resident when she heard staff #71 yelling and screaming at a resident he was angry and mean and loud, and that resident #35 was really upset and yelling at the CNA (staff #71). Staff #8 stated that she told staff #71 to stop yelling and he ignored her, and when she finished providing care to the other resident, she told staff #71 again to stop yelling at resident #35 and staff #71 continued to ignore her, and continued to yell at the resident. Staff #8 stated that after staff #71 yelled at resident #35, she put a note about the incident in the Administrator's office. Staff #8 stated that she thought she was supposed to call the Administrator right away, but it just happened right before shift change and she was really busy and she had worked with (staff #71) for a long time and didn't want to get him into trouble. Staff #8 stated that she thought it was verbal abuse. During an interview conducted on (MONTH) 29, 2019 at 3:31 p.m. with the Administrator, he stated that the nurse should have reported the first incident to him (on (MONTH) 2 at 8:50 p.m.) and that if she had reported the allegation to him, the second incident (on (MONTH) 3 at 5:50 a.m.) would not have happened, because staff #71 would have already been suspended from duty. The Administrator stated that the nurses (staff #8 and staff #72) did not report the allegations of abuse to him and they did not follow their policy. The Administrator stated that although staff #71 was not scheduled to work on Saturday or Sunday (August 3 and 4), he could have picked up additional shifts as he was not suspended until (MONTH) 5, 2019. An interview was conducted on (MONTH) 30, 2019 at 10:00 a.m. with the Administrator and the Director of Nursing (staff #15). The Administrator stated that when there is an allegation of abuse, staff are to report the allegation to the Administrator and the charge nurse is to report the allegation to the Administrator. He said an allegation is to be reported within 2 hours to the State Agency and APS, and if staff is accused of abuse, the staff must leave the facility immediately. The Administrator stated that a plan of correction regarding the substantiated allegation of abuse had been initiated as part of the facility's QAPI (Quality Assurance Performance Improvement) program, which included in-service education regarding abuse to all staff, and will continue to be provided to staff each month. Review of the facility's QAPI Plan of Correction revealed the following: -Training regarding abuse will be provided monthly (instead of annually). -Training will include specific examples, and will be written and verbal. -The contact numbers for reporting abuse allegations will be posted at the time clock. -Staff will be encouraged to speak with Administration members for any questions they may have about proper reporting. -Progress will be followed up by the QAPI committee and continually discussed for any modifications. -Weekly auditing of all reportable events was initiated on (MONTH) 12, 2019 and was on-going at the time of the recertification survey. Review of the QAPI Audits revealed that audits were done weekly from (MONTH) 2019 through (MONTH) 2019 regarding allegations of abuse. In addition, the in-service records revealed that in-services for all staff members regarding abuse, reporting abuse and resident rights were provided in August, (MONTH) and (MONTH) 2019. Review of a staff in-service titled, Resident Rights and Abuse revealed Our facility does not condone resident abuse by anyone including staff members. The in-service included that all alleged abuse must be reported to the State Agency and APS within 2 hours after finding out about the event, even though an investigation has not been completed yet. The staff training also included that leaving a message on someone's phone is not considered reporting abuse. In addition, the

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) employee involved in the suspected incident is to be sent home immediately. If the Director of Nursing or the Executive Director is not in the building, the charge nurse or Manager on Duty will be responsible for sending home a person (employee) that is suspected of abuse. Review of the Abuse policy revealed that if abuse is witnessed or suspected, the Executive Director (ED) will be notified, and the ED and the witness who is reporting will notify Adult Protective Services, the State Survey Agency and Law Enforcement. The policy included that the ED will begin an investigation immediately and suspected abuse will be reported in accordance with timeframes and standards required by CMS (Centers for Medicare and Medicaid Services). If an employee is suspected of being the abuser, they will be suspended until the investigation is complete.
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, review of the State Agency data base and policies and procedures, the facility failed to ensure that allegations of abuse involving two residents (#35 and #51) were reported immediately to the Administrator, and reported within two hours after the allegations were made to the State Agency and to Adult Protective Services (APS). Delayed notification to the Administrator regarding allegations of abuse, could result in a delay in corrective action being implemented at the time of the allegations and State Agencies not being aware of possible abuse situations. Findings include: Regarding resident #51 and staff #71: -Resident #51 was admitted on (MONTH) 23, 2019 with [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set) assessment dated (MONTH) 30, 2019 included the resident had a BIMS (Brief Interview for Mental Status) score of 15, which indicated intact cognition. Review of a facility's investigative report revealed that on (MONTH) 2, 2019 at 8:50 p.m., resident #51 told a RN (Registered Nurse/staff #72) that a LNA (Licensed Nursing Assistant/staff #71) had told him that he didn't need his pills and to shut up and go back to sleep. The report included the resident had asked staff #71 to tell the nurse that he was ready for more pain medication and that staff #71 yelled at him and told him You don't need any pills so shut up and go back to sleep. The report included that the allegation was unsubstantiated as there were no witnesses. Per the report, staff #72 thought the incident would be verbal abuse and thought about calling, but she wasn't sure so she left a note in the Administrator's mailbox instead. The report further included the allegation of abuse was not reported to the State Agency and APS until (MONTH) 5, 2019. Review of the State Agency data base revealed that although the events described in the facility's investigation occurred on (MONTH) 2, 2019 at 8:50 p.m., the allegation of abuse was not reported to the State Agency and APS until (MONTH) 5, 2019 at 7:43 p.m. During an interview conducted on (MONTH) 29, 2019 at 12:18 p.m. with a RN (staff #72), she stated that early on the night shift (on (MONTH) 2, 2019), she responded to a call light for resident #51. She said the resident told her that staff #71 had told him to shut up and go to bed. Staff #72 stated that she did not report the allegation of abuse, because she had not witnessed it happening, and assumed that she had to witness abuse to report it. She said that she assumed the charge nurse (RN/staff #8) had notified the Administrator. Staff #72 stated that she or the charge nurse (staff #8) could have reported the allegation to the Administrator. During an interview conducted on (MONTH) 29, 2019 at 12:54 p.m. with the Charge Nurse (RN/staff #8), she stated that early on the night shift on (MONTH) 2, 2019, staff #72 told her that resident #51 had said that staff #71 told him to shut up. Staff #8 stated she asked staff #72 to write a statement, which she put in the Administrator's office. Staff #8 said the event occurred on the weekend and the Administrator's office was closed. Regarding resident #35 and staff #71: -Resident #35 was admitted on (MONTH) 22, 2019 with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 29, 2019 included the resident had a BIMS score of 9, which indicated moderate cognitive impairment. The MDS also included the resident had highly impaired hearing, had clear comprehension of others and was able to make himself understood. Review of the facility's investigative report revealed that on (MONTH) 3, 2019 at 5:50 a.m., a Registered Nurse (RN/staff #8) witnessed a licensed nursing assistant (LNA/staff #71) yelling at resident #35. The incident took place in a common area. Per the report, staff #71 was continuously arguing and screaming loud at resident #35. Staff #8 told staff #71 to stop and get away from the resident, but staff #71 stated no and told her to back him up. The report included an interview with staff #71, who reported that the resident was getting all of the coffee creamers so he told him to stop, but he kept getting into them. Staff #71 reported that the resident was very hard of hearing and he was speaking loudly to him and the nurse told him to stop and he was upset with the nurse for not backing him up. He denied yelling at the resident. The report further included that a total of three staff witnessed the incident and all reported the same thing. Per the report, verbal abuse was substantiated based on witness statements and interviews, and staff #71 was terminated. The report further included the allegation of abuse was not reported to the State Agency and APS until (MONTH) 5, 2019. Review of the State Agency data base revealed that although the events described in the facility's investigation occurred on (MONTH) 3, 2019 at 5:50 a.m., it was not reported to the State Agency and APS until (MONTH) 5, 2019 at 7:43 p.m. In an interview conducted on (MONTH) 29, 2019 at 12:54 p.m. with staff #8, she stated that later on that same night shift (early in the morning on (MONTH) 3, 2019) she was providing care to a resident when she heard staff #71 yelling and screaming at a resident (#35) he was angry and mean and loud, and that resident #35 was really upset and yelling at the CNA (staff #71). Staff #8 stated that she told staff #71 to stop yelling and he ignored her, and when she finished providing care to the other resident, she told staff #71 again to stop yelling at resident #35 and staff #71 continued to ignore her, and continued to yell at the resident. Staff #8 stated that after staff #71 yelled at resident #35, she put a note about the incident in the Administrator's office. Staff #8 stated that she thought she was supposed to call the Administrator right away, but it just happened right before shift change and she was really busy and she had worked with (staff #71) for a long time and didn't want to get him into trouble. Staff #8 stated that she thought it was verbal abuse. During an interview conducted on (MONTH) 29, 2019 at 3:31 p.m. with the Administrator (staff #74), he stated the nurses (staff #8 and staff #72) did not report the allegations of abuse to him and should have, and that they did not follow their policy. An interview was conducted on (MONTH) 30, 2019 at 10:00 a.m., with the Administrator and the Director of Nursing (staff #15). The Administrator stated that when there is an allegation of abuse, staff are to report the allegation to him. The Administrator stated that the allegation is to be reported within 2 hours to the State Agency and APS. The Administrator stated that a plan of correction regarding the substantiated allegation of abuse had been initiated as part of the facility's QAPI (Quality Assurance Performance Improvement) program, which included in-service education to all staff and will continue to be provided to staff each month. Review of the facility's QAPI Plan of Correction revealed the following: -Training regarding abuse will be provided monthly (instead of annually). -Training will include specific examples, and will be written and verbal. -The contact numbers for reporting abuse allegations will be posted at the time clock. -Staff will be encouraged to speak with Administration members for any questions they may have about proper reporting. -Progress will be followed up by the QAPI committee and continually discussed for any modifications. -Weekly auditing of all reportable events was initiated on (MONTH) 12, 2019 and was on-going at the time of the recertification survey. Review of the QAPI audits revealed that audits were done weekly from (MONTH) 2019 through (MONTH) 2019 regarding allegations of abuse. In addition, the in-service records revealed that in-services for all staff members regarding abuse, reporting abuse and resident rights were provided in August, (MONTH) and (MONTH) 2019.

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) Review of a staff in-service titled, Resident Rights and Abuse revealed that all alleged abuse must be reported to the State Agency, police and APS within 2 hours after finding out about the event, even though an investigation has not been completed yet. The staff training included that leaving a message on someone's phone is not considered reporting abuse. Review of the Abuse policy revealed that if abuse is witnessed or suspected, the Executive Director (ED) will be notified, and the ED and the witness who is reporting will notify Adult Protective Services, the State Survey Agency and Law Enforcement. The policy included that the ED will begin an investigation immediately and suspected abuse will be reported in accordance with timeframes and standards required by CMS (Centers for Medicare and Medicaid Services).
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record reviews, staff interviews, review of the State Agency data base, facility documentation and policies and procedures, the facility failed to initiate timely abuse investigations involving two residents (#35 and #51) and failed to prevent the potential for further abuse at the time of the allegations. The deficient practice could result in the potential for further abuse of residents. Findings include: Regarding resident #51 and staff #71: -Resident #51 was admitted on (MONTH) 23, 2019 with [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set) assessment dated (MONTH) 30, 2019 included the resident had a BIMS (Brief Interview for Mental Status) score of 15, which indicated intact cognition. Review of a facility's investigative report revealed that on (MONTH) 2, 2019 at 8:50 p.m., resident #51 told a RN (Registered Nurse/staff #72) that a LNA (Licensed Nursing Assistant/staff #71) had told him that he didn't need his pills and to shut up and go back to sleep. The report included the resident had asked staff #71 to tell the nurse that he was ready for more pain medication and that staff #71 yelled at him and told him You don't need any pills so shut up and go back to sleep. The report included the allegation was unsubstantiated as there were no witnesses. Per the report, staff #72 thought the incident would be verbal abuse and thought about calling, but she wasn't sure so she left a note in the Administrator's mailbox instead. The report further included that staff #71 was not removed from providing care to residents until (MONTH) 5, 2019, and that an investigation was not initiated until (MONTH) 5. Review of the State Agency data base revealed that although the events described in the facility's investigation occurred on (MONTH) 2, 2019 at 8:50 p.m., an investigation was not initiated until (MONTH) 5 and staff #71 was not removed from providing care to residents until (MONTH) 5. During an interview conducted on (MONTH) 29, 2019 at 12:18 p.m. with a RN (staff #72), she stated that early on the night shift (on (MONTH) 2, 2019), she responded to a call light for resident #51. She said the resident (#51) told her that staff #71 had told him to shut up and go to bed. Staff #72 stated that she did not report the allegation of abuse, because she had not witnessed it happening, and assumed that she had to witness abuse to report it. She said that she assumed the charge nurse (RN/staff #8) had notified the Administrator. Staff #72 stated that she or the charge nurse (staff #8) could have reported the allegation to the Administrator. She said that although she did ask staff #71 not to enter resident #51's room for the rest of the night shift, she did not remember if he had continued to provide care to residents for the remainder of his shift, or if he had finished his shift. Staff #72 stated that staff #71 should have probably been sent home. When asked how she ensured that resident's were protected from the potential for further abuse after the allegation was made that night, she said that she did not know. During an interview conducted on (MONTH) 29, 2019 at 12:54 p.m. with the Charge Nurse (RN/staff #8), she stated that early on the night shift on (MONTH) 2, 2019, staff #72 told her that resident #51 had said that staff #71 told him to shut up. Staff #8 stated she asked staff #72 to write a statement, which she put in the Administrator's office. Staff #8 said the event occurred on the weekend and the Administrator's office was closed. Regarding resident #35 and staff #71: -Resident #35 was admitted on (MONTH) 22, 2019 with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 29, 2019 included the resident had a BIMS score of 9, which indicated moderate cognitive impairment. The MDS also included the resident had highly impaired hearing, had clear comprehension of others and was able to make himself understood. Review of the facility's investigative report revealed that on (MONTH) 3, 2019 at 5:50 a.m., a Registered Nurse (RN/staff #8) witnessed a licensed nursing assistant (LNA/staff #71) yelling at resident #35. The incident took place in a common area. Per the report, staff #71 was continuously arguing and screaming loud at resident #35. Staff #8 told staff #71 to stop and get away from the resident, but staff #71 stated no and told her to back him up. The report included an interview with staff #71, who reported the resident was getting all of the coffee creamers so he told him to stop, but he kept getting into them. Staff #71 reported that the resident was very hard of hearing and he was speaking loudly to him and the nurse told him to stop and he was upset with the nurse for not backing him up. He denied yelling at the resident. The report further included that a total of three staff witnessed the incident and all reported the same thing. Per the report, verbal abuse was substantiated based on witness statements and interviews, and staff #71 was terminated. The report further included that staff #71 was not removed from providing care to residents until (MONTH) 5, 2019, and that an investigation was not initiated until (MONTH) 5. In an interview conducted on (MONTH) 29, 2019 at 12:54 p.m. with staff #8, she stated that later on that same night shift (early in the morning on (MONTH) 3, 2019), she was providing care to a resident when she heard staff #71 yelling and screaming at a resident (#35) he was angry and mean and loud, and that resident #35 was really upset and yelling at the CNA (staff #71). Staff #8 stated that she told staff #71 to stop yelling and he ignored her, and when she finished providing care to the other resident, she told staff #71 again to stop yelling at resident #35 and staff #71 continued to ignore her, and continued to yell at the resident. Staff #8 stated that after staff #71 yelled at resident #35, she put a note about the incident in the Administrator's office. Staff #8 stated that she thought she was supposed to call the Administrator right away, but it just happened right before shift change and she was really busy and she had worked with (staff #71) for a long time and didn't want to get him into trouble. Staff #8 stated that she thought it was verbal abuse. During an interview conducted on (MONTH) 29, 2019 at 3:31 p.m. with the Administrator, he stated that the nurse should have reported the first incident to him (on (MONTH) 2 at 8:50 p.m.) and that if she had reported the allegation to him, the second incident (on (MONTH) 3 at 5:50 a.m.) would not have happened, because staff #71 would have already been suspended from duty. The Administrator stated that although staff #71 was not scheduled to work on Saturday or Sunday (August 3 and 4), he could have picked up additional shifts as he was not suspended until (MONTH) 5, 2019. An interview was conducted on (MONTH) 30, 2019 at 10:00 a.m. with the Administrator and the Director of Nursing (staff #15). The Administrator stated that when there is an allegation of abuse, staff are to report the allegation to the Administrator and the charge nurse is to report the allegation to the Administrator. He said an allegation is to be reported within 2 hours to the State Agency and APS, and if staff is accused of abuse the staff must leave the facility immediately. The Administrator stated that a plan of correction regarding the substantiated allegation of abuse had been initiated as part of the facility's QAPI (Quality Assurance Performance Improvement) program, which included in-service education regarding abuse to all staff, and will continue to be provided to staff each month. Review of the facility's QAPI Plan of Correction revealed the following: -Training regarding abuse will be provided monthly (instead of annually). -Training will include specific examples, and will be written and verbal. -The contact numbers for reporting abuse allegations will be posted at the time clock. -Staff will be encouraged to speak with Administration members for any questions they may have about proper reporting. -Progress will be followed up by the QAPI committee and continually discussed for any modifications. -Weekly auditing of all reportable events was initiated on (MONTH) 12, 2019 and was on-going at the time of the recertification survey. Review of the QAPI Audits revealed that audits were done weekly from (MONTH) 2019 through (MONTH) 2019 regarding allegations of abuse. In addition, the in-service records revealed that in-services for all staff members regarding abuse, reporting abuse and resident rights were provided in August, (MONTH) and (MONTH) 2019.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035240	A. BUILDING _____ B. WING _____	**10/30/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF LAKE HAVASU	**2781 OSBORNE DRIVE LAKE HAVASU CITY, AZ 86406**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) Review of a staff in-service titled, Resident Rights and Abuse In-Service revealed Our facility does not condone resident abuse by anyone including staff members. The in-service included that the employee involved in the suspected incident is to be sent home immediately. If the Director of Nursing or the Executive Director is not in the building, the charge nurse or Manager on Duty will be responsible for sending home a person (employee) that is suspected of abuse. Review of the Abuse policy and procedure revealed that if abuse is witnessed or suspected, the ED will begin an investigation immediately, and if an employee is suspected of being the abuser, they will be suspended until the investigation is complete.