STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035059	A. BUILDING _____ B. WING _____	**01/25/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF SCOTTSDALE	**3293 NORTH DRINKWATER BOULEVARD SCOTTSDALE, AZ 85251**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, resident and staff interviews, facility documents and policy and procedures, the facility failed to ensure one resident (#8) was free from neglect which resulted in harm, failed to ensure one resident (#284) was free from verbal abuse by a staff member and failed to ensure that one resident (#283) was free from physical abuse by another resident (#11). The resident census was 41. Findings include: -Resident #8 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the fall care plan revised on 7/11/18 revealed the resident had an actual fall (guided to floor by staff) with no injury. The interventions included to anticipate and meet resident needs, encourage the resident to seek assistance with all transfers, ensure that call light and frequently used items are within reach before leaving the room, keep resident's room free of clutter and well lit, and resident is to be a two person transfer. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed to have severe cognitive impairment. The functional assessment of the MDS indicated the resident had no impairment with range of motion to her extremities. An Interdisciplinary Team (IDT) Fall Report dated 11/15/18 included that resident #8 had a fall on 11/14/2018 at 1:37 p.m. The events surrounding the fall included that a Certified Nursing Assistant (CNA/staff #67) called over the radio for assistance in the room of resident #8. Staff #67 was observed laying on the floor next to the resident who was also laying on the floor. The CNA was bleeding from his left orbital socket. Resident #8 was on her back with her head resting on the bed frame of her roommate's bed and was in distress and was crying. The note included the CNA was attempting to transfer the resident by himself from the wheelchair to the bed, and lost his balance due to the resident moving in the opposite direction of intended movement. The report included that the Registered Nurse (RN) requested the assistance of the Assistant Director of Nursing/Interim Director of Nursing (ADON/IDON). The resident was observed to have an injury to her right arm and possible injury to her head/neck. The resident was not moved off the floor, her neck was stabilized and 9-1-1 was called. The Fall Report further included that the fall was discussed with the Interdisciplinary Team (IDT) and that the resident had been a two person transfer since 7/2018. Per the report, staff #67 was not using his gait belt during the transfer, and he was transferring the resident by himself without another staff member. According to the fall investigation completed by the IDT, the resident had a witnessed fall with a major injury, which was directly correlated to the fact that the CNA was not following the resident's current plan of care for a two person transfer and was not in compliance with the facility's policy to use a gait belt with all transfers. The CNA was terminated as a result of the IDT investigation. The resident was placed on Alert Charting, the care plan was updated and a Fall Risk Assessment was completed. The physician and responsible party were notified. Review of the CNA task documentation revealed it was updated on 11/15/18 to reflect that resident #8 required the assistance of two staff with transfers. A physician hospital progress note dated 11/16/2018 included the resident was admitted due to being transferred from the wheelchair to standing, and while standing fell out of their grasp. Patient reports the staff person lost their balance while standing, and fell on to the patient. The hospital course included the resident had a humeral head fracture status [REDACTED]. The fall care plan was updated on 11/18/18 to reflect that the resident had a witnessed fall with major injury (right humeral head fracture) on 11/14/18. An observation was conducted on 1/23/19 at 8:46 a.m. of the resident in bed. With the assistance of a Spanish-speaking Certified Nursing Assistant, the resident was asked to move her right arm. The resident demonstrated severe limited ability with range of motion to the right shoulder, right elbow and right wrist. The resident was able to move all fingers on the right hand. An interview was conducted on 1/25/19 at 8:54 a.m. with a CNA (staff #19), who was observed with a gait belt around her waist. Staff #19 stated she always has it with her and it is required to be used for all resident assisted transfers. Staff #19 stated that she checks the Kardex and the Task List to see what specific care is needed for residents or she asks the therapist or nurse. Staff #19 stated if she doesn't feel comfortable transferring a resident, she will ask for help. Staff #19 stated that she remembered they were transferring resident #8 with one person and that she had transferred her by herself more than once, because there was nothing on the Kardex or on the task list to tell her that the resident needed to be transferred with two people. She stated that she doesn't have access to the care plan. An interview was conducted on 1/25/19 at 9:18 a.m. with the ADON (staff #29), who stated that ever since she had been working at the facility (8/08/17), she felt resident #8 was a two person transfer, but it was not determined for her to be a two person transfer until her first fall in (MONTH) (YEAR). Staff #29 stated when she was investigating the (MONTH) fall, the information regarding the need for two persons for transfers was not on the Kardex/Task list, so it was added then. Staff #29 stated she doesn't think the CNA's have access to the care plans, but she wasn't sure. An interview was conducted on 1/25/19 at 9:38 a.m. with the Administrator (Abuse Prohibition Officer/staff #40), who stated that staff are trained on physical, emotional, mental, sexual, financial and verbal abuse and neglect. Staff #40 stated that staff are made aware of what is included in the various types of abuse and that it was just reviewed along with resident rights at the all staff meeting. Staff #40 stated the leadership team will make a determination on whether or not an incident is abuse/neglect. Staff #40 stated neglect examples would include a resident demanding care and was purposely ignored or the provision of goods and services or types of care were not being provided. Staff #40 stated that the CNA (staff #67) was terminated, because of not following the resident's care plan and our policy for transfers. Another interview was conducted on 1/25/19 with ADON (staff #29), who stated she convened the IDT Fall team the day after the fall. She said the appropriate people (physician, responsible party) were notified and the resident was sent out to the hospital. Staff #29 further stated that based on the definition of neglect (as discussed above), she would now consider what occurred as neglect. An interview was conducted on 1/25/19 with the DON (staff #53), who stated that they looked at the fall as any other fall. She said resident #8 had a witnessed fall and sustained a fracture, and was sent to the hospital. She said for those reasons, she didn't feel it was neglect and it was not reported to the State Agency or other agencies. Staff #53 agreed that based on the definition of neglect as discussed, she would now consider what occurred as neglect.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035059	A. BUILDING _____ B. WING _____	01/25/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF SCOTTSDALE	3293 NORTH DRINKWATER BOULEVARD SCOTTSDALE, AZ 85251

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) An interview was conducted on 1/25/19 at 11:45 a.m., with the CNA (staff #67). Staff #67 stated that he was provided training by the facility on how to do transfers and how to obtain information regarding transfer needs of residents from the computer system. Staff #67 stated the facility policy was to use a gait belt for all transfers and he used a gait belt for all transfers, except for one incident. Staff #67 stated the incident was when resident #8 fell . He said that he had taken the gait belt out of his pocket to use the restroom and didn't put it back and forgot about it. Staff #67 stated that Prior to that day we always used two people to transfer her, but that day I didn't call for help because I was just trying to get her laid down before the end of my shift and I had things to do. -Resident #284 was admitted on (MONTH) 16, 2019, with [DIAGNOSES REDACTED]. Review of the care plan initiated on (MONTH) 17, 2019, revealed the resident was on antidepressant medication related to depression. Interventions included redirection and activities of choice for crying, self-isolation or verbalization of sadness. Review of an activity of daily living (ADL) care plan revealed resident #284 has an ADL self-care performance deficit related to impaired mobility. Interventions included for PT/OT evaluation and treatment as per physicians orders and to encourage resident to participate to the fullest extent possible with each interaction. Review of the nurse's notes dated (MONTH) 19, 2019, revealed the resident was alert and oriented x 4, and has a right leg and left arm in an immobilizer. Per the note, the resident was extensive assist of one person for bed mobility and toileting, and a two-person extensive assist for transfers. The admission Minimum Data Set (MDS) assessment dated (MONTH) 23, 2019, revealed the resident scored a 15 on the Brief Interview for Mental Status (BIM's), indicating the resident was cognitively intact. The MDS also revealed the resident did not have any behaviors. Review of the facility's investigation dated (MONTH) 23, 2019, revealed that on (MONTH) 18, 2019, resident #284 was very upset about her therapy that day. She reported that the therapy staff (#68 and #21) were yelling and cussing at her. The resident reported that she wanted to work with physical therapy (PT), as she had already received a shower from occupational therapy (OT). She stated that when she went to the therapy gym, the therapist (Certified Occupational therapy assistant/COTA/staff #68) told her If you get your butt down here we can work. Resident #284 further reported that the therapists were yelling at her and told her that it took 30 minutes to get her out of bed and walk her and that was her therapy for the day. She stated it was not correct that it took her 30 minutes to get her out of bed. The resident stated that one of the therapists called her a name (B word), but she wasn't sure which one. She said that made her angry and she called the therapist the same name. Further review of the investigative report revealed a statement by the physical therapy assistant (PTA/staff #21). Staff #21 explained that it took 30 minutes for the resident to get out of bed, take a shower and walk 25 feet. After the shower, resident #284 came to the therapy gym and was upset, so she told the resident to sit down and she would explain it to her. Staff #21 reported that as she was explaining the issue regarding the therapy minutes, the resident started to escalate, so she backed off. Staff #21 stated that there were two other therapists in the room, one was an Occupational Therapist (OT/staff #23) and the other was staff #68 (COTA). She reported at that point, staff #68 tried to explain the situation to the resident. Staff #21's statement included that none of the therapists were yelling at the resident. Continued review of the investigative report revealed a statement from staff #23. Staff #23 said when resident #284 entered the gym, she was upset because it took 35 minutes to get her out of bed. Per staff #23, that time was included as part of her therapy and the resident did not understand that. Staff #23 reported that she saw staff #21 back down, when resident #284 started yelling and swearing. Staff #23 stated at that point, staff #68 started to jump in and started yelling If you want therapy get out of bed. Staff #23 stated that resident #284 and staff #68 were yelling at each other. She said that she did not hear anyone say the B word. Staff #23's statement also included that she could see how it was aggressive from the resident's point of view and she wouldn't talk to a patient like that. The investigative report also included a statement by a Certified Nursing Assistant (CNA/staff #51), who was present during the incident. Staff #51 reported that staff #21 was explaining to the resident about her physical therapy minutes and the resident was upset saying that it did not take her 30 minutes to get out of bed. Staff #51 reported that staff #68 was yelling at the resident, as she was trying to get the resident back to her room. Staff #51 stated the resident was strolling away when staff #68 kept at it and told the resident If you don't like it you can always go home. Staff #51 reported that she did not hear any cuss words from anyone. Per the report, a statement from staff #68 revealed that she tried to calm resident #284 down by trying to explain some items to her. Staff #68 reported the resident started wheeling out of the gym and she was trying to explain things to her, so she kept saying loudly Ma'am Ma'am. She stated that she did not think her actions were uncalled for. Review of staff #68's personal employee file revealed that staff #68 had a disciplinary warning on (MONTH) 13, (YEAR). Staff #68 was observed by a staff member talking to another staff member about a resident during a smoking break. It was reported that staff #68 was cussing and using profanity about a resident in front of other residents and a family member, who were a few feet away. Additional documentation via email included that based on their investigation the B word was never used. However, it was determined that staff #68 did yell at the resident even after the resident turned around to wheel herself out of the gym. Due to the previous warnings and this incident, staff #68 lacked the ability to provide good customer service and has demonstrated a pattern of behaviors, as a result staff #68 was terminated. The investigative report concluded that no staff witnessed staff #21 or staff #68 cussing at the resident, therefore the allegation was unsubstantiated. However, despite witnesses reporting that staff #68 was yelling at the resident, even as the resident was attempting to leave the area, the facility did not substantiate that verbal abuse had occurred. During an interview conducted with resident #284 on (MONTH) 23, 2019 at 8:28 a.m., she stated that on (MONTH) 18, 2019 she went to the physical therapy gym to talk to staff about her therapy. She said that a physical therapy assistant (PTA/staff #21) and a certified occupational therapy assistant (COTA/staff #68) were very rude to her. She stated that staff #21 and #68 were yelling at her and staff #68, who has never worked with her before continued to yell at her. She stated that staff #68 was yelling saying If you don't like it you can leave even as the Certified Nursing Assistant CNA (staff #51) was pushing her wheelchair out of the therapy gym. An interview was conducted on (MONTH) 25, 2019 at 8:38 a.m. with staff #21. She stated that on (MONTH) 18, 2019, she was working with resident #284. She stated that they used 30 minutes of therapy time getting the resident up from bed, giving her a shower and they walked the resident. She said the resident came to the therapy gym wanting the remaining minutes of her therapy later that day. Staff #21 said that she tried to explain to the resident that her 30 minutes of therapy was completed, as it had been used up when they got her up from bed to the shower and did some walking. She stated the resident was not happy when she heard this and started arguing in a loud voice, almost yelling. At this point, staff #21 stated that she backed down and said they could talk about it later and the resident was satisfied with that explanation. Staff #21 said that staff #68 was sitting in the corner of the room and tried to reiterate what she had just said, but by this time resident #284 and staff #68 were both yelling at each other. Staff #21 stated the resident was yelling and staff #68 was also yelling back at her. Staff #21 stated that staff #68 could have handled the situation differently and she felt that staff #68 was aggravating the situation further. She stated staff #68 has a tendency to get frustrated and escalates easily. An interview was conducted on (MONTH) 25, 2019, at 9:37 a.m. with the Director of Nursing (DON/staff #53), who stated that they conducted employee interviews during the investigation and based on the employee interviews they determined that it was not abuse, since there were no cuss words used. Staff #53 stated that during their investigation it was determined that only staff #68 was yelling. She stated that they fired staff #68, because she was yelling at a resident and did not provide good customer service. An interview was conducted with staff #51 on (MONTH) 25, 2019 at 11:09 a.m. Staff #51 stated that resident #284 went to the therapy room to speak to staff #21 to see if she was going to get therapy that day. Staff #21 told resident #284 that she already had her therapy for 30 minutes this morning. Staff #51 stated that staff #21 was telling the resident that it took her 30 minutes to get the resident out of bed to the shower, which was her total therapy time for the day. She said that is when staff #68 who was sitting in the far corner intervened and said that resident #284 only has 30 minutes allotted to her and she has used it all. Staff #51 stated that resident #284 turned around to leave and staff #68 started yelling at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035059	A. BUILDING _____ B. WING _____	01/25/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF SCOTTSDALE	3293 NORTH DRINKWATER BOULEVARD SCOTTSDALE, AZ 85251

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) resident stating she only gets 30 minutes and that's how much her insurance pays and if the resident does not like it she can leave. Staff #51 stated that there were no swear words used, but staff #68 was yelling at the resident. She stated that staff #68 should have let the other therapist finish her conversation with the resident and not interfere and it would have been easier to explain rather than start yelling. -Resident #11 was admitted on (MONTH) 29, 2003, with [DIAGNOSES REDACTED]. Review of the MDS assessment dated (MONTH) 21, (YEAR), revealed the Brief Interview for Mental Status (BIMS) was not conducted, however, the resident was assessed to have moderate cognitive impairment. The MDS also included the resident had difficulty focusing, was short-tempered and gets restless at times. Review of a care plan revealed that resident #11 displays behaviors of physical aggression. -Resident #283 was admitted on (MONTH) 23, (YEAR), with [DIAGNOSES REDACTED]. Review of the MDS assessment dated (MONTH) 8, (YEAR), revealed a BIMS interview was not attempted as the resident was rarely/never understood. The MDS included that resident #11 had moderate cognitive impairment. A nurse's weekly skin check and wound assessment dated (MONTH) 12, (YEAR) included resident was involved in a resident to resident altercation in which he was struck on the arm. No bruising, laceration, open skin or injury observed from residents altercation . Review of the facility's investigative report revealed that on (MONTH) 12, (YEAR) at approximately 7:00 p.m., resident #11 had been sitting next to resident #283 after dinner at the nurse's station. Resident #283 was talking/mumbling to himself quietly as he does most of the time. Staff observed resident #11 reach over and swing at resident #283's face. The first swing did not make contact, but resident #11 swung again immediately and resident #283 put his forearm in front of his face, so resident #11 made contact with resident #283's shoulder/upper arm. This incident was witnessed by facility staff who separated the residents just as resident #11 made contact with the second swing. An interview was conducted on (MONTH) 23, 2019 at 2:05 p.m., with a CNA (staff #3). She stated the residents were roommates and were seated in wheelchairs side by side at the nurses station. She said that resident #283 was talking to himself like he usually does and resident #11 thought he was talking about him. Staff #3 said that resident #11 is not very verbal and gave resident #283 an agitated look and then tried hitting him. She said when resident #11 missed, he swung again and this time he was able to punch resident #283 on his left arm. She stated that he did not hit him hard. Staff #3 stated they were quick in separating both residents and no injuries were noted on either resident. Staff #3 also stated that resident #11 has exhibited some aggressive behaviors in the past, but can easily be redirected and will calm down in a few minutes if removed from the situation. An interview was conducted on (MONTH) 24, 2019 at 9:52 a.m., with a Registered Nurse (staff #44). She stated that both resident's were sitting at the nurses station when she heard one of the CNA's yell no and that's when she turned and saw the CNA's in between the two residents. She said there were no injuries and they made sure both residents were safe. She said they kept them separated and placed them in separate rooms and did frequent checks (every 15 minutes for an hour then frequently). Staff #44 stated they notified the Administrator and the Director of Nursing. An interview was conducted on (MONTH) 25, 2019 at 9:38 a.m., with the Administrator (staff #40). He stated that abuse is covered in orientation and in staff meetings and is discussed on a weekly basis. He stated when there is a resident to resident altercation, employees should make sure the resident is safe and separate them from the situation. During an interview conducted on (MONTH) 25, 2019 with the Director of Nursing (staff #53), she said when there is a resident to resident altercation, staff should notify the nurse or charge nurse. She stated that staff are aware that they are mandated reporters of any kind of abuse. Review of the facility's Abuse policy revealed the facility will strive to prevent the abuse of all residents. Our objective is to provide a safe haven for our residents through preventative measures that protect every resident's right to freedom from abuse. We care for residents with a [DIAGNOSES REDACTED]. The policy included that by definition, abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Willful, as used in this definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Abuse includes verbal abuse, sexual abuse, physical abuse and mental abuse. Potential abusers can be residents, employees or family members. The policy also included that If abuse is witnessed or suspected, the resident's safety will immediately be secured. Prompt reporting and investigation will be utilized to identify the validity of findings and reasonable measures will be implemented to deter further incidents of abuse.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to implement their abuse policy, by failing to identify an incident of neglect involving a staff member and a resident (#8), and by failing to report the incident of neglect to the State Agency and Adult Protective Services (APS). The resident census was 41. Findings include: Resident #8 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the fall care plan revised on 7/11/18 revealed the resident had an actual fall (guided to floor by staff) with no injury. The interventions included to anticipate and meet resident needs, encourage the resident to seek assistance with all transfers, ensure that call light and frequently used items are within reach before leaving the room, keep resident's room free of clutter and well lit, and resident is to be a two person transfer. An Interdisciplinary Team (IDT) Fall Report dated 11/15/18 included that resident #8 had a fall on 11/14/2018 at 1:37 p.m. The events surrounding the fall included that a Certified Nursing Assistant (CNA/staff #67) called over the radio for assistance in the room of resident #8. Staff #67 was observed laying on the floor next to the resident who was also laying on the floor. The CNA was bleeding from his left orbital socket. Resident #8 was on her back with her head resting on the bed frame of her roommate's bed and was in distress and was crying. The note included the CNA was attempting to transfer the resident by himself from the wheelchair to the bed, and lost his balance due to the resident moving in the opposite direction of intended movement. The report included that the Registered Nurse (RN) requested the assistance of the Assistant Director of Nursing/Interim Director of Nursing (ADON/IDON). The resident was observed to have an injury to her right arm and possible injury to her head/neck. The resident was not moved off the floor, her neck was stabilized and 9-1-1 was called. The Fall Report further included that the fall was discussed with the Interdisciplinary Team (IDT) and that the resident had been a two person transfer since 7/2018. Per the report, staff #67 was not using his gait belt during the transfer, and he was transferring the resident by himself without another staff member. According to the fall investigation completed by the IDT, the resident had a witnessed fall with a major injury, which was directly correlated to the fact that the CNA was not following the resident's current plan of care for a two person transfer and was not in compliance with the facility's policy to use a gait belt with all transfers. The CNA was terminated as a result of the IDT investigation. The resident was placed on Alert Charting, the care plan was updated and a Fall Risk Assessment was completed. The physician and responsible party were notified. A physician hospital progress note dated 11/16/2018 included the resident was admitted due to being transferred from the wheelchair to standing, and while standing fell out of their grasp. Patient reports the staff person lost their balance while standing, and fell on to the patient. The hospital course included the resident had a humeral head fracture status [REDACTED]. Further review of the investigative documentation revealed the facility had not identified this incident as neglect, therefore, did not notify the State Agency and APS. An interview was conducted on 1/25/19 at 9:38 a.m. with the Administrator (Abuse Prohibition Officer/staff #40), who stated the types of abuse staff are trained on include physical, emotional, mental, sexual, financial, verbal and neglect. Regarding allegations of abuse/neglect, he stated they initiate an investigation and the leadership team will make a determination on whether or not it is abuse. Staff #40 stated neglect examples would include a resident demanding care and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035059	A. BUILDING _____ B. WING _____	01/25/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF SCOTTSDALE	3293 NORTH DRINKWATER BOULEVARD SCOTTSDALE, AZ 85251

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** - Few	(continued... from page 3) was purposely ignored or the provision of goods and services or types of care were not provided. He stated the CNA (staff #67) was terminated, because he did not follow the resident's care plan and our policy regarding transfers. Staff #40 also stated that staff members have been educated that they have to call the State Agency, along with other agencies within 2 hours of becoming aware of the incident. An interview was conducted on 1/25/19 at 9:38 a.m. with staff #29, who stated that based on the definition of neglect as discussed (above), she would now consider what occurred as neglect. An interview was conducted on 1/25/19 with the Director of Nursing (DON/staff #53), who stated that they looked at the fall as any other fall. She said resident #8 had a witnessed fall and sustained a fracture, and was sent to the hospital. She said for those reasons, she didn't feel it was neglect and it was not reported to the State Agency or other agencies. Staff #53 agreed that based on the definition of neglect as discussed (above) she would now consider what occurred as neglect. An interview was conducted on 1/25/19 at 11:45 a.m., with the CNA (staff #67) who transferred the resident. He stated the facility policy was to use a gait belt for all transfers. He said that he used a gait belt for all transfers, except for one incident when resident #8 fell . Staff #67 stated he had taken the gait belt out of his pocket to use the restroom and didn't put it back and forgot about it. Staff #67 stated that Prior to that day we always used two people to transfer her, but that day I didn't call for help because I was just trying to get her laid down before the end of my shift and I had things to do. Review of the facility's Abuse policy revealed the facility will strive to prevent the abuse of all residents. Our objective is to provide a safe haven for our residents through preventative measures that protect every resident's right to freedom from abuse. We care for residents with a [DIAGNOSES REDACTED]. The policy included that by definition, abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Willful, as used in this definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Abuse includes verbal abuse, sexual abuse, physical abuse and mental abuse. Potential abusers can be residents, employees or family members. The policy included that if abuse is witnessed or suspected, reporting and an investigation will take place in this manner: 1. Executive Director (ED) will be notified. 2. ED and witness who is reporting will notify the following entities: a. Adult Protective Services b. Ombudsman 3. State Survey Agency d. Law Enforcement when applicable e. Facility Director of Nursing (DON) 3. DON will notify the following: a. Physician b. Responsible Party c. Corporate Clinical Team 4. ED will begin investigation immediately and complete within 5 days using the Abuse Investigation Packet. Suspected abuse will be reported in accordance with timeframes and standards required by the State Agency. If an employee is suspected of being the abuser, they will be suspended until the investigation is complete. If the investigation finds that abuse is substantiated and the abuser is an employee, they will be immediately terminated and licensure reporting as applicable will be done. The policy further included that If abuse is witnessed or suspected, the resident's safety will immediately be secured. Prompt reporting and investigation will be utilized to identify the validity of findings and reasonable measures will be implemented to deter further incidents of abuse.
F 0608 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to ensure (1) employees report any suspicion of a crime against any resident, according to timelines; (2) post the notice of employee rights; and (3) prohibit and prevent retaliation for reporting.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documents and policy and procedures, the facility failed to report a suspicion of a crime (neglect) to law enforcement involving a staff member and a resident (#8). Findings include: Resident #8 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the fall care plan revised on 7/11/18 revealed the resident had an actual fall (guided to floor by staff) with no injury. The interventions included to anticipate and meet resident needs, encourage the resident to seek assistance with all transfers, ensure that call light and frequently used items are within reach before leaving the room, keep resident's room free of clutter and well lit, and resident is to be a two person transfer. An Interdisciplinary Team (IDT) Fall Report dated 11/15/18 included that resident #8 had a fall on 11/14/2018 at 1:37 p.m. The events surrounding the fall included that a Certified Nursing Assistant (CNA/staff #67) called over the radio for assistance in the room of resident #8. Staff #67 was observed laying on the floor next to the resident who was also laying on the floor. The CNA was bleeding from his left orbital socket. Resident #8 was on her back with her head resting on the bed frame of her roommate's bed and was in distress and was crying. The note included the CNA was attempting to transfer the resident by himself from the wheelchair to the bed, and lost his balance due to the resident moving in the opposite direction of intended movement. The report included that the Registered Nurse (RN) requested the assistance of the Assistant Director of Nursing/Interim Director of Nursing (ADON/IDON). The resident was observed to have an injury to her right arm and possible injury to her head/neck. The resident was not moved off the floor, her neck was stabilized and 9-1-1 was called. The Fall Report further included that the fall was discussed with the Interdisciplinary Team (IDT) and that the resident had been a two person transfer since 7/2018. Per the report, staff #67 was not using his gait belt during the transfer, and he was transferring the resident by himself without another staff member. According to the fall investigation completed by the IDT, the resident had a witnessed fall with a major injury, which was directly correlated to the fact that the CNA was not following the resident's current plan of care for a two person transfer and was not in compliance with the facility's policy to use a gait belt with all transfers. The CNA was terminated as a result of the IDT investigation. Further review of the investigative documentation revealed the facility had not identified this incident as neglect and therefore, did not notify law enforcement. An interview was conducted on 1/25/19 at 9:38 a.m. with the Administrator (Abuse Prohibition Officer/staff #40), who stated that staff are trained on physical, emotional, mental, sexual, financial and verbal abuse and neglect. Staff #40 stated the leadership team will make a determination on whether or not an incident is abuse/neglect. Staff #40 stated neglect examples would include a resident demanding care and was purposely ignored or the provision of goods and services or types of care were not being provided. Staff #40 stated that the CNA (staff #67) was terminated, because of not following the resident's care plan and our policy for transfers. He further stated that staff members have been educated that the facility has to call the State Agency, along with other agencies, including law enforcement when appropriate, within the required time frames. An interview was conducted on 1/25/19 at 9:38 a.m. with staff #29, who stated that based on the definition of neglect as discussed (above), she would now consider what occurred as neglect. An interview was conducted on 1/25/19 with the DON (staff #53), who stated that they looked at the fall as any other fall. She said resident #8 had a witnessed fall and sustained a fracture, and was sent to the hospital. She said for those reasons, she didn't feel it was neglect and it was not reported to the State Agency or other agencies. Staff #53 agreed that based on the definition of neglect as discussed, she would now consider what occurred as neglect. An interview was conducted on 1/25/19 at 11:45 a.m., with the CNA (staff #67) who transferred the resident. He stated the facility policy was to use a gait belt for all transfers. He said that he used a gait belt for all transfers, except for one incident when resident #8 fell . Staff #67 stated he had taken the gait belt out of his pocket to use the restroom and didn't put it back and forgot about it. Staff #67 stated that Prior to that day we always used two people to transfer her, but that day I didn't call for help because I was just trying to get her laid down before the end of my shift and I had things to do. Review of the facility's Abuse policy revealed that the facility will strive to prevent the abuse of all residents. Our objective is to provide a safe haven for our residents through preventative measures that protect every resident's right to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035059	A. BUILDING _____ B. WING _____	01/25/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF SCOTTSDALE	3293 NORTH DRINKWATER BOULEVARD SCOTTSDALE, AZ 85251

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 0608 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) freedom from abuse. The policy included that by definition, abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Willful, as used in this definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Abuse includes verbal abuse, sexual abuse, physical abuse and mental abuse. Potential abusers can be residents, employees or family members. The policy included that if abuse is witnessed or suspected, reporting and an investigation will take place in this manner: 1. Executive Director (ED) will be notified. 2. ED and witness who is reporting will notify the following entities: a. Adult Protective Services b. Ombudsman 3. State Survey Agency d. Law Enforcement when applicable e. Facility Director of Nursing (DON) 3. DON will notify the following: a. Physician b. Responsible Party c. Corporate Clinical Team 4. ED will begin investigation immediately and complete within 5 days using the Abuse Investigation Packet. Suspected abuse will be reported in accordance with timeframes and standards required by the State Agency. If an employee is suspected of being the abuser, they will be suspended until the investigation is complete. If the investigation finds that abuse is substantiated and the abuser is an employee, they will be immediately terminated and licensure reporting as applicable will be done. The policy further included that If abuse is witnessed or suspected, the resident's safety will immediately be secured. Prompt reporting and investigation will be utilized to identify the validity of findings and reasonable measures will be implemented to deter further incidents of abuse.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, facility documentation and policy and procedures, the facility failed to report an incident of neglect involving one resident (#8) to the State Agency and to Adult Protective Services (APS). The resident census was 41. Findings include: Resident #8 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the fall care plan revised on 7/11/18 revealed the resident had an actual fall (guided to floor by staff) with no injury. The interventions included to anticipate and meet resident needs, encourage the resident to seek assistance with all transfers, ensure that call light and frequently used items are within reach before leaving the room, keep resident's room free of clutter and well lit, and resident is to be a two person transfer. An Interdisciplinary Team (IDT) Fall Report dated 11/15/18 included that resident #8 had a fall on 11/14/2018 at 1:37 p.m. The events surrounding the fall included that a Certified Nursing Assistant (CNA/staff #67) called over the radio for assistance in the room of resident #8. Staff #67 was observed laying on the floor next to the resident who was also laying on the floor. The CNA was bleeding from his left orbital socket. Resident #8 was on her back with her head resting on the bed frame of her roommate's bed and was in distress and was crying. The note included the CNA was attempting to transfer the resident by himself from the wheelchair to the bed, and lost his balance due to the resident moving in the opposite direction of intended movement. The report included that the Registered Nurse (RN) requested the assistance of the Assistant Director of Nursing/Interim Director of Nursing (ADON/IDON). The resident was observed to have an injury to her right arm and possible injury to her head/neck. The resident was not moved off the floor, her neck was stabilized and 9-1-1 was called. The Fall Report further included that the fall was discussed with the Interdisciplinary Team (IDT) and that the resident had been a two person transfer since 7/2018. Per the report, staff #67 was not using his gait belt during the transfer, and he was transferring the resident by himself without another staff member. According to the fall investigation completed by the IDT, the resident had a witnessed fall with a major injury, which was directly correlated to the fact that the CNA was not following the resident's current plan of care for a two person transfer and was not in compliance with the facility's policy to use a gait belt with all transfers. The CNA was terminated as a result of the IDT investigation. The physician and responsible party were notified. However, the State Agency and APS were not notified of the incident of neglect within two hours. An interview was conducted on 1/25/19 at 9:38 a.m. with the Administrator (Abuse Prohibition Officer/staff #40), who stated that neglect examples would include a resident demanding care and was purposely ignored or the provision of goods and services or types of care were not provided. He stated that staff members have been educated that they have to call the State Agency, along with other agencies within two hours of becoming aware of the incident. An interview was conducted on 1/25/19 with the Director of Nursing (DON/staff #53), who stated that they looked at the fall as any other fall. She said resident #8 had a witnessed fall and sustained a fracture, and was sent to the hospital. She said for those reasons, she didn't feel it was neglect and it was not reported to the State Agency or other agencies. Staff #53 agreed that based on the definition of neglect as discussed, she would now consider what occurred as neglect. Review of the facility's Abuse policy revealed that if abuse is witnessed or suspected, reporting and an investigation will take place in this manner: 1. Executive Director (ED) will be notified. 2. ED and witness who is reporting will notify the following entities: a. Adult Protective Services b. Ombudsman 3. State Survey Agency d. Law Enforcement when applicable e. Facility Director of Nursing (DON) 3. DON will notify the following: a. Physician b. Responsible Party c. Corporate Clinical Team 4. ED will begin investigation immediately and complete within 5 days using the Abuse Investigation Packet. Suspected abuse will be reported in accordance with timeframes and standards required by the State Agency.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, facility documents and policy and procedure, the facility failed to ensure safe water temperatures were maintained in eight resident rooms. The facility census was 41. Findings include: During an observation conducted on 1/22/19 at 2:35 p.m., the water temperature of the restroom sink in room [ROOM NUMBER]-1 was checked and was 135 degrees Fahrenheit (F). This resident was able to use the restroom sink. During an observation conducted on 1/22/19 at 2:58 p.m., the water temperature in room [ROOM NUMBER]-1 was 130 degrees F. This resident was able to use the restroom. At this time, a family member stated sometimes the water feels a little hot and we are just careful. Additional water temperatures were taken on 1/22/19 at 3:43 p.m. and the following was found: -room [ROOM NUMBER]: water temperature was 126.6 degrees F -room [ROOM NUMBER]: water temperature was 126.2 degrees F -room [ROOM NUMBER]: water temperature was 130 degrees F -room [ROOM NUMBER]: water temperature was 135 degrees F -room [ROOM NUMBER]: water temperature was 134 degrees F -room [ROOM NUMBER]: water temperature was 131.5 degrees F On 1/22/19 at 4:15 p.m., the Environmental Services manager (staff #5) tested the water temperatures and the following was observed: -room [ROOM NUMBER]: water temperature was 122 degrees F -room [ROOM NUMBER]: water temperature was 132 degrees F -room [ROOM NUMBER]: water temperature was 136 degrees F -room [ROOM NUMBER]: water temperature was 118 degrees F -room [ROOM NUMBER]: water temperature was 140 degrees F -room [ROOM NUMBER]: water temperature was 124 degrees F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035059	A. BUILDING _____ B. WING _____	**01/25/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF SCOTTSDALE	**3293 NORTH DRINKWATER BOULEVARD SCOTTSDALE, AZ 85251**

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) During this observation, an interview was conducted with staff #5, who stated that water temperatures are checked weekly and documented and there have not been any problems. He stated the water should be run for 3-5 minutes before checking the temperatures. The facility immediately turned down the water temperatures at least twice and monitored the water temperatures every hour throughout the night. Facility water temperature logs were reviewed with the following results: -January (YEAR): all temperatures were either 101, 102 or 103 degrees F. -February (YEAR) through (MONTH) (YEAR): all temperatures were either 101, 102 or 103 degrees F. -August (YEAR): all temperatures were either 103 or 104 degrees F. -September (YEAR) through (MONTH) (YEAR): all temperatures were either 101, 102 or 103 degrees F. Review of the facility temperature log for (MONTH) 2019 revealed the water temperatures were checked on 1/21/19 and all temperatures in every room were either 101, 102 or 103 degrees F. In an interview conducted on 1/23/19 at 8:00 a.m. with the Executive Director (staff #40), he stated that he did not know why the water temperatures were so consistent on previous temperature checks. He said the facility has monitored the water temperatures throughout the night and have made adjustments to the temperature settings to get them back in the required ranges. He stated that he takes this very seriously and understands residents could be easily burned with high water temperatures. Staff #40 further stated he has made sure the team checking the temperatures are using good thermometers (new ones were purchased) and are following the correct procedures to check the temperatures accurately. Follow-up water temperatures were conducted on 1/23/19 at 11:20 a.m. with the following results: -room [ROOM NUMBER]: water temperature was 113 degrees F -room [ROOM NUMBER]: water temperature was 109.2 degrees F -room [ROOM NUMBER]: water temperature was 110.2 degrees F -room [ROOM NUMBER]: water temperature 103.2 degrees F -room [ROOM NUMBER]: water temperature 104.2 degrees F -room [ROOM NUMBER]: water temperature 96.5 degrees F -Shower 1: water temperature 98 degrees F Follow up water temperatures were taken on 1/25/19 at 8:05 a.m. and revealed the following: -room [ROOM NUMBER]: water temperature was 110.9 degrees F -room [ROOM NUMBER]: water temperature was 105.9 degrees F -room [ROOM NUMBER]: water temperature was 104.9 degrees F -room [ROOM NUMBER]: water temperature was 106.6 degrees F -Shower 2: water temperature was 104.3 degrees F Review of the facility policy titled Accidents and Supervision - Water Temperatures (undated), revealed the purpose of recording water temperatures is to assure that the facility is remaining free from [MEDICAL CONDITION] scalds, and that issues are addressed in a prompt and consistent manner. The policy described the process which included: the dial thermometer should be calibrated on a regular basis; insert the step of the thermometer under the running water, while also holding your hand under the water to see how the water feels on skin and test water at various locations throughout the facility. The policy further included that patient water temperatures should be between 105 F and 115 F, and that State law should be followed with temperatures between 95 F to 120 F. Results of testing should be recorded, discrepancies noted, water setting adjusted as needed, and retest as necessary.