STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035094	A. BUILDING _____ B. WING _____	11/26/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF SEDONA	505 JACKS CANYON ROAD SEDONA, AZ 86351

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 -** Few	**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 clinical record reviews, staff interviews, and facility documentation and policy, the facility failed to provide adequate supervision for two residents (#265 and #31) resulting in a resident to resident altercation between the residents. The sample size was four residents. The deficient practice could result in further incidents between residents. Findings include: -Resident #265 was admitted to the facility on (MONTH) 30, (YEAR) with a [DIAGNOSES REDACTED]. The resident's care plan dated (MONTH) 8, 2019, included that resident #265 resided in a secured unit related to dementia and depression with psychotic symptoms. The goal for this care plan was that the resident's safety would be maintained and the resident would wander about the unit without any occurrence of injury. The interventions included that the resident used a wanderguard, he required monitoring as much as possible to assure his safety, and that staff should keep the environment free of possible hazards. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 16, 2019, included a Brief Interview for Mental Status (BIMS) with a score of 3, indicating the resident had severe cognitive impairment. The MDS also included that the resident could be short-tempered, easily annoyed, and exhibited behaviors of pacing and rummaging. Review of a Nurse Practitioner (NP) progress note dated (MONTH) 23, 2019 revealed that resident #265 was roaming on the secured unit with behaviors of ongoing psychotic symptoms including manifestations of a need to stand close to peers on the unit at all times. Review of a progress note dated (MONTH) 4, 2019, revealed that resident #265 had to be constantly redirected away from another resident, who threatened to kick him. A progress note dated (MONTH) 8, 2019, revealed that resident #265 required constant supervision to keep him safe from harm. Review of a progress note dated (MONTH) 13, 2019 at 9:12 p.m., revealed that resident #265 invaded resident #31's personal space and resident #31 verbally threatened resident #265. Review of a Quality Assessment Tool dated (MONTH) 14, 2019, revealed that resident #265 had memory problems and daily behaviors that required maximum staff intervention. -Resident #31 was admitted to the facility on (MONTH) 4, 2019, with [DIAGNOSES REDACTED]. Review of an annual MDS assessment dated (MONTH) 11, 2019, included a BIMS score of 3, indicating the resident had severe cognitive impairment. The MDS did not indicate that the resident had any verbal or physical behaviors toward others. The resident's [MEDICAL CONDITION] medication care plan dated (MONTH) 2019, revealed that the resident had depression, anxiety, and aggression related to a [MEDICAL CONDITION] (TBI) with [MEDICAL CONDITION]. The interventions included discouraging inappropriate behaviors and monitoring and recording any displayed behavior or mood problem. A care plan for cognition showed that the resident had cognitive impairment as evidenced by forgetfulness, confusion, and disorientation. The plan included that the resident believed it was 1986 and had difficulty making decisions. A second care plan for cognitive loss and dementia noted the resident exhibited restlessness and wandering. One of the interventions for this care plan was to increase supervision as necessary. A quarterly MDS dated (MONTH) 16, 2019, revealed that the resident had verbal and physical behaviors directed towards others 1 to 3 days during the 7-day look-back period of the assessment. Review of a facility incident report dated (MONTH) 31, 2019 revealed that resident #31 had an incident with another resident (not resident #265) on (MONTH) 27, 2019, where he had struck the resident on the left cheek leaving a slight pink mark. The report indicated that resident #31 may have felt threatened having the other resident close to him and in an attempt to push her away, his reaction resulted in an incident. The report concluded that there were no further issues or altered behaviors by the resident and that he did not remember the incident. The investigation did not include any further interventions to prevent resident #31 from having future incidents with residents. Review of an Initial Psychiatric Evaluation dated (MONTH) 5, 2019, revealed that resident #31 was agitated, angry, and recently involved in an altercation with another resident. Staff reported that resident was having auditory and visual hallucinations. There was no evidence in resident #31's clinical record that any interventions, including increased supervision, had been put in place after the incident on (MONTH) 27, 2019 to prevent resident #31 from having further incidents with other residents. Review of a facility incident report dated (MONTH) 13, 2019, revealed that resident #265 wandered over to resident #31, who was sitting at a table eating. Resident #31 yelled that he didn't want resident #265 near him. When resident #265 leaned in closer to resident #31, resident #31 grabbed him by the throat leaving a pinkish mark on his neck. On (MONTH) 26, 2019 at 9:14 a.m., an interview was conducted with a Certified Nursing Assistant (CNA/staff #61), who stated that resident #265 wanders and will hold on to the other residents' arms. She said that if the resident tries to get away, resident 265's grip tightens and he will hold up his other hand and make a fist. She said that she and the other staff know that resident #265 is going to grab other residents or their things and that staff are supposed to keep an eye on him to prevent this. On (MONTH) 26, 2019 at 9:40 a.m., an interview was conducted with a Licensed [MEDICATION NAME] Nurse(LPN/staff #67), who stated that in order to prevent incidents, she needs to distract residents or intervene prior to the incident occurring. She said that resident #265 paces all the time and needs to be redirected when he heads toward other residents. She said that some residents are triggered by resident #265 when he comes near them. She said that resident #265 has a prior history of grabbing other residents and making a fist when he is being redirected. During an interview with the interim Director of Nursing (DON/staff #4) on (MONTH) 26, 2019 at 12:10 p.m., she said that wandering behaviors are appropriate on a dementia unit. She said if a resident needs a secured unit, it would be part of the care plan that the resident wanders and the plan may include interventions such as redirection. She said that staff would redirect to keep residents safe and evaluate to determine what might be escalating or triggering the resident. She said that care planned interventions are modified when they do not work. She said the facility looks at triggers to prevent incidents and to ensure that there are staff to intervene quickly when incidents occur or may occur. In an interview with a nurse consultant (staff #72) on (MONTH) 26, 2019 at 12:35 p.m., she said that the residents reside on a wandering unit and staff know resident behaviors on this unit and have interventions for the individual residents. She said that for resident #265, she could not find anything specific in the resident's care plan to address his intrusiveness and entering other resident's spaces but said that there was a general intervention to monitor the resident as close as

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) possible and that this means to be able to see the resident while he is around others so that he can be redirected when needed. During an interview with the administrator (staff #73) on (MONTH) 26, 2019 at 12:35 p.m., he stated that when an incident between residents occurs, he investigates and then based on the results of the investigation, he comes up with an action plan. He said that in this case, he was looking into more appropriate placement for resident #31 since wandering is expected in the secured unit and the resident lashed out when resident #265 wandered near him. Review of the facility's unsafe wandering policy revised (MONTH) 2014, revealed a policy statement that the facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. The policy implementation included that the staff will identify resident who are at risk for harm because of unsafe wandering and assess these resident for potentially correctable risk factors related to unsafe wandering. The policy included that the resident's care plan will indicate the resident is at risk for elopement or other safety issues and interventions to try to maintain safety, such as a detailed monitoring plan, will be included.