STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035096	A. BUILDING _____ B. WING _____	**08/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF SANDPOINTE, LLC	**2222 SOUTH AVENUE A YUMA, AZ 85364**

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 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on onsite investigation, interviews, review of facility documentation and policy, the facility failed to ensure that two residents, resident #142 and #134,were treated with respect and dignity and that the residents were cared for in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident 's individuality. This deficient practice could result in a lower quality of life for residents in the facility. The sample size was two residents. Findings include: -Resident # 142 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 13, indicating the resident was cognitively intact. An AZDHS reportable 5 day event form was completed and submitted on July 28, 2020 for an event that was reported to staff and State Agency on July 22, 2020 at 10:00 a.m. Review of this form revealed that Resident #142 requested Certified Nursing Assistant /Licensed Nursing Assistant(CNA/LNA/ staff #120) to change her brief. Staff #120 replied that she was too busy at the moment and she would get back to her. The resident stated that upon her return, the staff member stated that the resident was using too many briefs and was being changed every 30 minutes and that they would run out of briefs due to being changed so often. An investigation was opened regarding the incident, at which time staff #120 was suspended. During the investigation, the Director of Nursing (DON/staff #116) and the Assistant Director of Nursing (ADON/ staff # 51) spoke with several residents regarding their experience regarding staff at the facility. These interviews included one resident with a similar experience with staff #120. One of the residents, resident #134 was interviewed on July 27,2020 and stated that his overall experience with staff was good. However, he stated that staff #120 told him that he called too many times and was going to use all the briefs in the facility. He requested that she not provide care for him and stated that she was very rude. -Review of the clinical record for Resident #134 revealed that he was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) for Resident #134, dated August 3,2020, revealed a Brief Interview for Mental Status (BIMS) of 15, indicating the resident was cognitively intact. An interview with the Assistant Director of Nursing (ADON/staff #51) was completed on August 27, 2020 at 10:29 a.m The interview revealed that on July 22,2020, the ADON was made aware that resident #142 had claimed that staff #120 told resident #142 that she used too many briefs and called out too often on the morning of July 21,2020. The ADON was made aware of the incident by staff #80 on the morning of July 22, 2020. The ADON interviewed the resident on July 22, 2020. The ADON informed the Director of Nursing (DON) and the Human Resource Department at that time. The ADON stated that the process for such an allegation was to inform the DON, Administrator, and Social Services and open an investigation. She confirmed that the resident is to be interviewed within 2 hours of the allegation. During the interview, the ADON stated that staff #120 had to be told more than once about appropriate resident acknowledgement and task timelines. There was no prior concern with abuse. The ADON stated that the staff member was put on suspension immediately and was not permitted to return, Staff #120 was terminated July 31,2020 for a policy violation in relation to this incident. An interview was conducted on August 27, 2020 at 11:01 a.m. with Resident #142. The interview revealed that on the date of the incident staff #120 told her that there were no briefs available and that they were waiting for a shipment of briefs. The resident stated that the staff member told her that she could sit on a pad for an hour and then she would put on a brief. Staff #120 returned some time later and put a clean brief on the resident. The resident said it was approximately 2.5 hours before she returned however, staff #120 told the resident that it was 20 minutes. Resident #142 stated that she was wet and staff #120 didn't clean her before putting on a clean brief. The resident stated that the next day the nurse (RN/staff #80) asked why she seemed upset and she explained the situation that occurred on the previous day. Staff #80 told the resident he would report the incident to the Director of Nursing (DON). He told the resident that it should be reported as that was not proper care. The resident agreed. An interview with the Director of Nursing (DON/staff#116) was conducted on August 27,2020 at 11:15 a.m. The interview revealed that once any complaint is made by a resident, it is investigated. This investigation process included interviews with the complainant, other residents and staff. If the complaint is abuse, the administrator is made aware immediately and he will do all necessary reporting within he 2 hour time frame. The DON further stated that in the incident involving resident #142, the resident stated that staff #120 told her she used all the briefs and called too much. He stated that the resident and employee were interviewed at once and the employee was put on suspension pending results of the investigation. He further stated that the employee was terminated based on the cumulative interviews done during the investigative process. An interview was conducted with CNA/ LNA/ Staff #114 on August 27,2020 at 1:32 p.m The interview revealed that the policy for staff regarding any type of abuse in the facility is that it is to be reported at once. The report is made to a nurse, ADON, DON or administration. The expectation is that once reported, an investigation will be opened immediately and the staff member will be put on suspension until the investigation is completed. Staff #114 stated that they do have inservices regarding treatment of [REDACTED]. They are done periodically and are most often taught by the DON or ADON. During the interview, staff #114 stated that he had worked with CNA/LNA/Staff #120 and she was not the greatest. He stated that although he never heard staff # 120 treat any resident disrespectfully, he had residents complain about her. He said that one current resident and two previous residents stated she was rude and the did not want her to provide them with any care. Review of the employee file of staff #120 revealed that an employee disciplinary form was filled out indicating that the employee was disciplined and given a verbal warning on May 4, 2020 based on an incident that occurred on April 23, 2020 at 7:00 p.m. This incident violated a company core value of Mutual Respect towards a co-worker , which is part of the facility policy of Professional conduct. The employee was given a verbal warning and signed the disciplinary documentation regarding the incident on May 7, 2020. An additional incident occurred on July 21, 2020 indicative of the policy violation of the Professional Conduct Policy. This incident resulted in the termination of employee #120 on July 31, 2020. Review of the employee file revealed that Staff #120 signed a copy of the document titled Resident Rights which includes verbiage that all residents are to be treated with consideration, respect, and dignity The document was signed on February 19,2020. Review of the Professional Conduct Policy stated that as an employee it is expected that a high degree of personal integrity be exhibited at all times. This included sincere respect for the rights and feelings of others as well as refraining from any harmful behavior or behavior that may be viewed as unfavorable by current or potential customers or the public at large. The policy further stated that examples of violations of this policy include disrespect of coworkers, residents or guests ,substandard work and a violation of the code of conduct.
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.**

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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, staff interviews and policy and procedures, the facility failed to ensure that an allegation of misappropriation of resident #92's property was reported to appropriate State agency's within the required timeframe. Findings include: Resident #92 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the residents personal property inventory of personal effects dated March 8, 2020 revealed the resident had a purse which was listed as a personal item upon admission. Review of a facility grievance report and resolution form dated June 8, 2020, revealed the resident told staff that her purse was missing, and that her I.D. card, social security card, passport, and pictures of grandkids were in the missing purse. The documentation included the resident told staff that $100 was in the missing purse. Review of the facility's investigation revealed that the State survey agency was notified with an online report on June 11, 2020 at 4:15 p.m. Review of the facility's investigative documentation revealed the resident was missing a purse. The facility searched for the purse and interviewed multiple staff, but it was not found. On June 11, 2020 at 4:27 p.m. the facility completed an online report to the Yuma Police Department regarding the missing property. Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 13, indicating the resident was cognitively intact. An interview was conducted on August 27, 2020 at 12:00 p.m. with resident #92 and she stated that she felt that the purse was missing. An interview was conducted on August 27, 2020 at 2:15 p.m. with the Director of Nursing (DON/staff #116). He stated that the Administrator was not available for an interview. He stated that as the DON he had been involved in the investigation into the resident's claim. He stated that the resident was missing her purse, the facility initiated an investigation, and that the police were contacted. When asked if Adult Protective Services (APS) had been contacted he stated that he had no documentation that APS had been contacted. He reviewed the documentation and stated that if this had occurred now, he would report the allegations within the required timeframe of 24 hours to the appropriate agencies, including the State survey agency, and APS. Review of the facility's Abuse policy revealed that 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. If abuse is witnessed or suspected the Executive Director (ED) will notify the following entities, the Ombudsman, APS, state survey agency, law enforcement (where applicable), and the DON. Suspected abuse will be reported in accordance with timeframes and standards required by CMS.