

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035062	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/17/2025
NAME OF PROVIDER OR SUPPLIER  Desert Haven Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2645 East Thomas Road Phoenix, AZ 85016	

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 0684  Level of Harm - Actual harm  Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals.  (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0684  Level of Harm - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, interviews and review of facility policy and procedure, the facility failed to ensure physician orders were followed regarding blood glucose monitoring; and, failed to ensure a healthcare provider was notified of abnormal blood glucose reading for one of 3 sampled resident (#44). The deficient practice led to the resident being admitted to the intensive care unit of a hospital with hyperglycemia and treatment for diabetic ketoacidosis. Findings Include: Resident #44 was admitted on [DATE], and re-admitted on [DATE], with diagnoses of type 1 diabetes mellitus, cerebral infarction, long term use of insulin, unspecified dementia, unspecified psychosis, and other sequelae of cerebral infarction. A care plan dated June 7, 2024, revealed Resident #44 had diabetes mellitus. Interventions included: diabetic medication and fasting serum blood sugar as ordered by physician; to educate resident regarding medications and importance of compliance and have resident verbally state an understanding; monitor/document/report as needed any signs and symptoms of hyperglycemia (increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, pain, Kussmaul breathing, acetone breath, stupor, and coma) and hypoglycemia (sweating, tremor, increased heart rate, pallor, nervousness, confusion, slurred speech, lack of coordination, and staggering gait). The care plan did not include monitoring of BS (blood sugar) with either accuchecks (fingerstick BS monitoring device) or Dexcom device (continuous glucose system sensor). A physician order dated August 28, 2024 included for the following: Dexcom G7 Sensor to inject 1 dose (sensor) subcutaneously one time a day every 10 day(s) for type 1 diabetes mellitus, and to install on upper arm and alternate arms each dose, and to remove per schedule; and, Keep Dexcom G7 sensor charged at all times. A physician order dated June 26, 2025, included to change Dexcom G7 Sensor every 10 days. A physician order dated September 3, 2025, included for Humalog Injection Solution 100 unit/ml (Insulin Lispro), to inject 8 units subcutaneously every 4 hours as needed for hyperglycemia, and may give additional 8 units if BS &gt;300. A quarterly minimum data set (MDS) assessment dated [DATE] a BIMS (brief interview for mental status) score of 10, indicating resident #44 had moderate cognitive impairment. Active diagnoses of diabetes mellitus and psychotic disorder. The documentation revealed a discrepancy in Section N, which showed that Resident #44 received insulin injections 7 out of 7 days or since admission, and that the documentation was not check/checked in the box to indicate that the resident was taking a hypoglycemic medication (insulin) during the last 7 days or since admission. The behavior note dated September 16, 2025 revealed resident was alert and oriented x 2 with confusion and frequently refusing cares. The documentation also included glucose monitoring as ordered with no signs/symptoms of hypo or hyperglycemia. A behavior note dated September 17, 2025 included the resident demanded his insulin that morning and the nurse explained that insulin was held because resident's BS was 89. The documentation also included that the resident took his medications and his insulin needed from Accucheck. A care plan revised on September 18, 2025 included the resident exhibited maladaptive behaviors as evidence by refusing medication and care, and repetitively asking for Accuchecks to be done and demanding insulin multiple times per day. Interventions included to conduct an evaluation of the behavioral symptoms to determine what strengths or needs are communicated via the behavior; to emphasize soothing, kind, slow and compassionate speech, do not rush or hurry, and use body language that communicates patience; to give psychoactive medication as ordered; and, to record behaviors/medication side effects, report changes to facility psychiatric practitioner. The behavior note dated September 19, 2025 revealed the resident was alert and oriented, tolerated medication administration as well; and that, the resident will come to the nurse's station to get his blood sugar checked and short acting was given. A behavior note dated September 30, 2025 included the resident was compliant with medication administration; and, will come to the nurse's station to ask to get his blood sugar checked. The order administration note dated October 4, 2025 revealed BS of 102 mg/dl (milligrams/deciliter). The order administration note dated October 5, 2025 revealed BS of 113 mg/dl. The order administration note dated October 6, 2025 revealed BS of 90 mg/dl. The order administration note dated October 7, 2025 revealed BS of 65 mg/dl. The order administration note dated October 8, 2025 revealed BS of 96 mg/dl. Despite documentation of low BS readings, there was no evidence the resident was monitored for sign/symptoms of hypoglycemia, actions were taken to address the low blood sugar; and that, the physician was notified. The blood sugar summary record for October 8, 2025 revealed the resident had a BS reading of 216 mg/dl. A physician order dated October 15, 2025 included for Insulin</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews, review of clinical record, and review of facility policy and procedure, the facility failed to ensure the medical record was complete and accurate regarding blood glucose monitoring for one resident (#44). The deficient practice could lead to incomplete and inaccurate medical record.-Findings Include:Resident #44 was admitted on [DATE], and re-admitted on [DATE], with diagnoses of type 1 diabetes mellitus, cerebral infarction, long term use of insulin, unspecified dementia, unspecified psychosis, and other sequelae of cerebral infarction.A quarterly minimum data set (MDS) assessment dated [DATE], revealed Resident #44 had a brief interview for mental status (BIMS) assessment score of 10, indicating moderate cognitive impairment. Section I revealed Resident #44 had active diagnoses of diabetes mellitus and psychotic disorder.A care plan dated June 7, 2024, revealed Resident #44 had diabetes mellitus, with interventions that included:-Diabetic medication as ordered by physician-Fasting serum blood sugar as ordered by physicianNo evidence was found in the care plan regarding monitoring blood glucose (blood sugar / BS) with either accucheck (fingerstick BS monitoring device) or dexcom device (continuous glucose system sensor). Additionally, the care plan revealed the most recent revision was on June 25, 2025.A physician order dated May 24, 2024, included for vital signs per facility policy.Physician orders dated August 28, 2024, included:-Dexcom G7 Sensor (continuous glucose system sensor), to inject 1 dose (sensor) subcutaneously one time a day every 10 days for type 1 diabetes mellitus, and to install on upper arm and alternate arms each dose, and to remove per schedule.-Keep Dexcom G7 sensor charged at all times.A physician order dated June 26, 2025, included to change Dexcom G7 Sensor every 10 days.A physician order dated and signed by a Nurse Practitioner (NP / Staff #27) on October 24, 2025, included to check BS four times a day, at 9:00 A.M., 12:00 P.M., 5:00 P.M., and 9:00 P.M.Another physician order dated October 24, 2025, included for Humalog Injection Solution 100 unit/ml (Insulin Lispro), to inject 6 units subcutaneously before meals and at bedtime (7:30 A.M., 11:00 A.M., 4:00 P.M., and 8:00 P.M.) for diabetes, and to hold if BS &lt;120, and to scan Dexcom G7 Sensor, and keep it charged. The clinical record and revealed the following regarding BS readings (values / numerical data) for Resident #44:October 24, 2025:-An Orders Administration Note revealed the resident refused insulin administration 2 times.-There was no evidence of any BS readings. October 25, 2025:-No evidence of any BS readings. October 26, 2025:-An Orders Administration Note at 7:23 A.M. revealed no insulin was administered due to BS reading 63 and outside of parameters.-A Behavior Note revealed Resident #44 was compliant with BS checks and insulin administration, however there was no evidence of how many readings were taken, or what the BS values were. October 27, 2025:-An Orders Administration Note at 7:23 A.M. revealed no insulin was administered due to BS reading of 52, and outside of parameters.-There was no evidence of any other BS readings. October 28, 2025:-An Orders Administration Note revealed insulin was held due to BS reading 69.-There no evidence of any other BS readings. October 29, 2025:-An Orders Administration Note at 7:53 A.M. revealed no insulin was administered due to BS reading 53, outside of parameters.-There was no evidence of any other BS readings. October 30, 2025:-Orders Administration Notes at 9:45 P.M. and 9:47 P.M. revealed the resident refused to allow the nurse to check BS with dexcom device or check BS manually (fingerstick), and no insulin was administered.-There was no evidence of any other BS readings. October 31, 2025:-A Behavior Note at 12:16 A.M. revealed the resident refused to allow the nurse to check dexcom or check BS manually, and no insulin administered.-An Orders Administration Note at 8:41 P.M. revealed the resident refused multiple attempts of insulin administration.-There was no evidence of any other BS readings. November 1, 2025:-An Orders Administration Note revealed Resident #44 refused the dexcom sensor placement.-A Behavior Note revealed the resident was compliant with BS checks and insulin administration. -There was no evidence of how many BS readings were taken and when, nor what the BS values were. November 2, 2025:-A Vitals Log at 7:06 P.M. revealed a BS reading of 329-A Behavior Note at 9:37 P.M. revealed the resident was compliant with BS check and insulin injection.-There was no evidence of any other BS readings. November 3, 2025:-Orders Administration Notes at 7:37 A.M. and 4:09 P.M. both revealed no insulin was administered due to BS reading of 120, outside of parameters, and at 9:35 P.M. the resident refused the insulin for two attempts.-There was no evidence of any other BS readings. November 4, 2025:-A Behavior Note revealed the resident tolerated medication administration well and self-isolated in his room all day other than meal times and insulin administration. The note revealed no evidence of a BS reading. -An</p>		