STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035062	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Haven Care Center	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40581 Based on observations, staff and resident interviews, the facility failed to ensure that residents were were treated with dignity while dining by using disposable cutlery and dishware. The deficient practice could result in residents not able to exercise their right to be treated with respect and dignity. Findings include: During dining observation conducted on Monday, April 15, 2024 at 5:07 p.m., there were seven residents in the dining room eating dinner. The food, drinks and dessert for the seven residents were served in Styrofoam containers, cups, and bowls. The residents were also using plastic ware for utensils. In an interview One of the resident's (#80) stated that Styrofoam is used sometimes, but not all the time. An interview was conducted on April 16, 2024 at 12:35 p.m. with the dietary director (staff #85), who stated that meals were served on Styrofoam when there is an emergency situation and when the dishwasher staff calls off. He stated that the dishwashing staff (#135) called off on Monday, April 15, 2024, so he did not have anyone to wash the dinner dishes. The dietary director then said that staff #135 was not scheduled to work on Mondays and he was not always able to get a staff to stay to do the dishes on Monday nights, so they use Styrofoam dishware. He stated that the use of Styrofoam dishware, cups and bowls and plastic utensils usually occurs on a monthly basis; and that, the Administrator was aware that he did not have a dishwashing staff coverage on Monday nights and the facility was using Styrofoam dishware cups and bowls and plastic utensils occasionally to serve food/drinks to the residents. Further, the dietary director said that the residents have a right to a home-like environment, which included using proper dishware, cups, and utensils. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Executive Director (ED/staff #18) was conducted on April 16, 2024 at 1:07 p.m. The ED stated that he supervises the dietary manager/director (staff #85) who informs him when the kitchen needs staff. The ED said he does not review the schedule for the kitchen staff, so he was not aware of a dishwasher being needed on Monday nights; and that, he was just informed by staff #85 five minutes before this interview. The ED said that Styrofoam dishware cups and bowls and plastic utensils had not been used in the facility since the outbreak of COVID-19; and, it was his expectation for staff provide a homelike environment in dining room. The ED further stated it was his expectation that Styrofoam dishware, cups and bowls and plastic utensils would not be used. He stated that it was also his expectation that staff working the Monday night shift wash the dishes if there was not a dishwashing staff scheduled. The facility policy, Dining Room Service dated 2018 included that that individuals will be encouraged to receive their meals in the dining room. A comfortable, attractive atmosphere will be maintained in the dining room area.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on observations , staff interviews and review of facility policy and procedure, the facility failed to ensure that the living space, interior and fixtures were maintained in good repair/condition; and, failed to ensure clean and sanitary environment. The deficient practice could result in residents not being afforded a home-like environment. Findings include: During an observation of a resident (#63) room on April 15, 2024 at 11:12 a.m., the window blinds in the were observed broken on both sides in multiple places. There was a light brown substance that had run down the walls and was now dry and there was a strong odor of urine. The plaster and paint were chipped off from the wall by the mirror; and, there were multiple small holes and plaster chipped off on the wall just under the toilet paper holder. The vents located in the bathroom ceiling was covered in brown dust/dirt. In an observation of another room (#22) conducted on April 15, 2024 at 1:14 p.m., the window blinds were broken in multiple places. An interview was conducted on April 17, 2024 at 10:44 a.m. with a certified nursing assistant (CNA/staff #32), who stated that if there was something broken or damaged in the room, staff were to notify maintenance by informing the nurse who would then contact the maintenance staff. During the interview, and observation of the resident (#63) room was conducted with the CNA who stated that the window blinds appeared to have been replaced. Another observation of another resident room next door was conducted with the CNA who stated that the window blinds were broken and should be fixed. In an interview with the licensed practical nurse (LPN/staff #4) conducted on April 17, 2024 at 10:49 a.m., the LPN stated that anything that was broken, including walls and blinds, the nurses would notify maintenance staff. The LPN said that it was an expectation that blinds were replaced immediately, the walls were checked right away and wall repair was planned/scheduled. Further, the LPN said that if things were broken and/or not cleaned, it affects the residents' homelike environment. An interview was conducted on April 17, 2024 at 11:02 a.m. with the Central Supply Manager (staff #63) who stated that his job duties included facility maintenance. He stated that anyone including nurses, CNAs, housekeeping staff and the residents can report or enter a report order when repairs were needed. He stated that the Maintenance Director (staff #20) supervised the housekeepers and does a walk-through of the building daily; and that, the housekeepers should report any damage when they see it. He stated that blinds can be replaced the next day unless they need to be ordered; and, even then, they usually get them by the next day. He said he can also go to the store to purchase blinds and other supplies. The central supply manager stated that he has not noticed any broken blinds in the building. At the end of the interview, the central supply manager walked across the hall from the central supply room and saw that the blinds in room [ROOM NUMBER] were broken in multiple areas. 50026 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An observation of the bathroom of a room (#30) conducted on April 16, 2024 at 3:28 p.m. with the maintenance director who stated that housekeeping was expected to clean bathrooms, including the walls, sink, and vents. He then poked a white substance on the bathroom vent and there was a puff of white and brown substance that came out from the vent. The maintenance director said that the white and brown substance that came out of the vent was dust and should have been cleaned. Another observation of bathroom between two different rooms was conducted with the maintenance director. The bathroom wall was stained with brown substance; and, the maintenance director stated that he would call a pest control company and have them assess the stain because he does not know what the brown stain was. He then grabbed a paper towel and touched the substance, and it crumbled under his touch. The ventilation in the bathroom had dark brown flecks; and the maintenance director stated he expected housekeeping to clean vents and walls. The facility policy, Maintenance Services states that maintenance services shall be provided to all areas of the building, grounds, and equipment. The maintenance director is responsible for developing and maintaining a schedule of maintenance services to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on clinical record reviews, staff interviews and review of facility policy, the facility failed to ensure that Preadmission Screening and Resident Review (PASRR) was updated for two residents (#73 and #22); and failed to ensure level II determination was submitted for one resident (#22). The deficient practice could result in residents not receiving the care and services they needed. Findings include: -Resident #73 was admitted on [DATE] with diagnoses of bipolar disorder, major depressive disorder, severe intellectual disability. Review of the clinical record revealed that the resident had a new diagnoses of anxiety disorder on January 24, 2024. However, further review of the clinical record revealed no evidence that the PASSR Level I screening was completed after January 24, 2024. An interview was conducted on April 16, 2024 at 3:28 p.m. with the Social Services Director (staff #29), who stated that if a resident had a new psychiatric diagnosis, the PASRR needs to be updated. During the interview, a review of the clinical record was conducted with staff #29 who stated that the PASRR for resident #73 should have been updated when the resident had a new diagnosis of anxiety. She also stated that there was documentation that the resident had an intellectual disability, but there were no details regarding how the intellectual disability affected the resident's ability to complete activities of daily living, but this could have been assessed by observation and included on the PASRR. During an interview with the Director of Nursing (DON/staff #14) conducted on April 16, 2024 at 3:43 p.m., she stated that the PASRR needs to updated if the resident has a new psychiatric diagnosis. 46606 Regarding Resident #22 -Resident #22 was initially admitted to the facility on [DATE] with diagnoses that included cerebral infarction, adjustment disorder with mixed disturbance of emotions and conduct, mental disorder, adjustment disorder with depressed mod, major depressive disorder, and bipolar disorder. A Pre-Admission Screening and Resident Review of (PASRR) Level 1 screening dated September 21, 2021 included diagnoses of major depression, and bipolar disorder. The documentation also included that this was submitted for a PASRR level II determination. Review of the clinical record revealed a new diagnosis of schizoaffective disorder on January 7, 2022. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A psychiatric evaluation dated January 11, 2022 revealed the resident had schizoaffective disorder. However, there was no evidence that an updated PASRR I was completed to reflect the new diagnoses of schizoaffective disorder; and there was no evidence that the resident was referred to PASRR level II determination. Review of clinical noted dated October 3, 2023 through January 9, 2024, revealed evidence that the resident had episodes of yelling, using inappropriate language, inappropriate sexual behavior, and being verbally aggressive with staff. A behavioral care plan revised March 29, 2024 indicated that the resident displays behavioral symptoms which included delusions, inappropriate sexual behavior, yelling, and aggression. Interventions included to intervene when any inappropriate behavior is observed, use creative refocusing to alter behavior, and medication adjustment. An interview was conducted on April 16, 2024 at 2:08 p.m., with the Director of Social Services (staff #200), who stated that if a resident has a new mental disorder diagnoses after they have been admitted , a new PASRR should be re-accomplished and a referral for level II determination has to be submitted. Staff #200 noted that if a PASRR is not updated and level II determination is not completed, then there is a chance that the resident is not getting the treatment they need. Staff #200 also stated that when there is no outcome, it is hard to say why a PASRR is important other than it is a routine requirement. He also noted that he is not sure what the value of the PASRR is. Resident # 22's record was reviewed with staff #200 on April 16, 2024 at approximately 2:08 p.m. During the review, staff #200 confirmed that the resident's PASRR is from September 21, 2021. He noted that with a new diagnosis of schizoaffective disorder back in January 7, 2022, it should have triggered a new PASRR and a level II determination. Staff #200 agreed that an updated PASRR should have been accomplished and submitted for level II determination. An interview with the Director of Nursing (DON/staff #14) was conducted on April 16, 2024 at 2:42 p.m. Staff #14 stated that her expectation is that PASRR is completed for each resident. She noted that if there are changes in diagnoses then it should be updated. Staff #14 stated that the impact of not having an updated PASRR is that the care might not be according to the care plan and what they only know about. The DON further noted that she does not know what the impact of the PASRR but knows it is required. She indicated that the PASRR tells you what the diagnoses or any mental illness but that it is already available via reports. The DON noted that with regards to resident #22 having a new mental disorder diagnoses after admission, she stated there should have been an updated PASRR since the facility did a sweep on PASRR. Review of the facility's policy titled PASRR Guideline reviewed July 15, 2022 stated that Preadmission Screening and Resident Review (PASRR) is required for all individuals being considered for admission to a Medicaid-certified nursing facility be screened to determine if the person has, or is suspected of having, a mental illness, intellectual disability, or related condition. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy on PASRR Guideline included that the Preadmission Screening and Resident Review (PASRR) is guided by federal regulations that require all individuals being considered for admission to a Medicaid-certified nursing facility (NF) be screened prior to admission, to determine if the person has, or is suspected of having, a mental illness, intellectual disability, or related condition. PASRR helps to ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that all applicants to a Medicaid-certified nursing facility be evaluated for mental illness (MI) and/ intellectual disability (ID).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on observations, staff interviews and review of facility policy and procedure, the facility failed to ensure food items were labeled and dated when opened; and, failed to ensure that open food item was stored to maintain freshness and prevent contamination. Findings included: The initial tour of the kitchen was conducted on April 15, 2024 at 8:35 a.m. with the Dietary Director (staff #85). There was a 15-pound box of bacon, which was approximately half full in the large refrigerator. A white sheet of paper lay over the top of the bacon, but the bacon was not in a sealed bag/container. There was also approximately one fourth of shredded lettuce remaining in a two pound plastic bag that was not sealed, and the bag had no open date. The bread was located on a tray in the kitchen. A half a loaf of wheat bread was observed and there was no open date, six hamburger buns were in a plastic bag with no open date, and an open bag of twenty-three [NAME] Hawaiian Sweet Rolls did not have an open date. Staff #85 stated he thought that about half the bacon remained in the box and he was not sure if the bacon needed to be stored in a sealed container to maintain freshness. He agreed that the shredded lettuce should have been sealed. He stated that the bread is supposed to be thrown away after 6 days, but he did not know when the wheat bread, hamburger buns, or Hawaiian rolls had been opened. Staff #85 tested the Quat in a small red cleaning bucket with Quat test strip and stated that it should test around 200 parts per million (ppm) and tested at 400 ppm. Staff #85 stated that if the ppm is not accurate, the solution should be adjusted and tested again. He stated that the solution was too strong and needed more water. An interview was conducted on April 17, 2024 at 11:44 a.m. with the Executive Director (staff #18), who stated that open products should be dated and if refrigerated, the products should be sealed with a lid or stretch wrap. He stated that when products are not sealed, oxidation could occur, which creates and issue, and can effect nutritive value and quality. Staff #18 also stated that the Quat should be tested with the testing strips to ensure the correct potency for contaminants. The facility policy, Food Storage and Date Marking states that sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled (if not easily identifiable) and dated if stored for over 24 hours. Leftover food is used within seven (7) days or discarded. The facility Quaternary Sanitizer Test Strip directions states to dip the test strip in the quat solution for ten seconds and it should test at 200 ppm.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47954 Based on observations, clinical record review, staff interviews, review of facility documentation and policy, the CDC (Centers for Disease Control and Prevention) and CMS (Centers for Medicare and Medicaid Services) guidance, the facility failed to ensure enhanced barrier precautions (EBP) were implemented for one resident (#72). The deficient practice could result in transmission of multi-drug resistant organisms. Findings include: Resident #72 was admitted on [DATE] with diagnosis of hemiplegia, diabetes mellitus type 2, cerebral infarction, dementia, and gastrostomy status. A review of the quarterly MDS (minimum data set) assessment dated [DATE] revealed BIMS (brief interview of mental status) score of 03, indicating the resident had severe cognitive impairment. The MDS also included that the resident had a gastrostomy tube. The physician order dated August 25, 2022 included for PEG (Percutaneous endoscopic gastrostomy) tube placement 18fr x 45cm. for nutritional support. The care plan dated August 28, 2022 revealed that the resident required tube feedings related to a swallowing problem. Interventions included to monitor, document, and report any signs or symptoms of aspiration, fever, infection, tube dysfunction or malfunction, and abnormal breathing sounds. An observation was conducted on April 17, 2024 at 9:25 a.m. There were no signs related to EBP posted outside of the room of resident #18; and, there were no PPE (personal protective equipment) visible outside of the resident's room. An interview was conducted on April 17, 2024 at 9:40 a.m. with a licensed practical nurse (LPN/Staff #9) who stated that there were no precautions in use anywhere in the building. The LPN also stated that this made it easier for staff to take care of the residents as staff did not have to gown up. Further, the LPN said that EBP were only used for leaking wounds and major infections. During an interview with the Director of Nursing, (DON) conducted on April 17, 2024 at 10:30 a.m., the DON stated that there were no precautions in use in the building right now. The DON stated that she had reviewed the notice about EBP and she did not agree with it because it does not maintain a homelike environment. Further, the DON also stated that none of her residents meet the criteria for contact precautions. A review of the facility assessment revealed the services provided by the facility include infection prevention and control, including the identification and containment of infections, and the prevention of infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The CDC website on healthcare acquired infections revealed that the enhanced barrier precautions are an infection control intervention designed to reduce the transmission of resistant organisms that employ targeted gown and glove use during high-contact resident care activities. The CDC website further showed examples of high-contact resident care activities includes device care or use: central line, urinary catheter, feeding tube, or tracheostomy/ventilator. The CDC website further stated that the use of gown and glove for high-contact resident care activities is indicated when contact precautions do not otherwise apply. Updated July 12, 2022. https://cdc.gov/hai/containment/PPE-Nursing-Homes.html; however, enhanced barrier precautions were not noted for resident #72 who has a PEG tube and receives regular tube feedings. The CMS QSO-24-08-NH Memo dated March 20, 2024 included that EBP recommendations now include use of EBP for residents with chronic wounds or indwelling medical device during high-contact resident care activities regardless of their multidrug-resistant organism (MDRO) status, in addition to resident who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply. Indwelling medical device examples include central lines, urinary catheters, feeding tubes and tracheostomies. EBP should be used for any residents who meet the above criteria, wherever they resident in the facility. The effective date of this memo was April 1, 2024.