

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 09/05/2025
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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews, and review of facility policy, the facility failed to ensure one resident (#3) was provided wound care in accordance with physician orders and professional standards. The deficient practice could result in wounds worsening or becoming infected. Findings include: Resident #3 was admitted to the facility on [DATE] with diagnoses that included dementia with mood disturbance, muscle weakness, and type two diabetes mellitus. Review of the care plan focus, initiated December 12, 2024, revealed that Resident #3 had pressure ulcers. The entry listed an unstageable right ischium wound with a date of November 25, 2024, and an unstageable sacral wound with a date of July 14, 2025. Interventions in place included to provide wound care as ordered by the physician. Review of physician orders revealed the following active wound care orders: Right Ischium: Cleanse with wound cleanser, pat dry, apply skin prep to surrounding wound, pack with Dakin's soaked gauze, cover with dry dressing daily and PRN. Sacrum: Cleanse with wound cleanser, pat dry, apply skin prep to surrounding wound, pack with Dakin's soaked gauze, cover with dry dressing daily and PRN. Observation of wound care was conducted on September 3, 2025 at 1:31PM with a Licensed Practical Nurse (LPN/Staff #124) who served as the wound care nurse for the facility. When preparing the supplies for the wound care, the LPN soaked gauze with Dakin's Half Strength Solution and placed it into a cup. While doing this, the LPN stated that she was told by the wound provider to not clean the wound, but to instead only put the Dakin's soaked gauze into the wound. The LPN stated that she was unsure if this was right, but that this was how she was instructed to do it. During the wound care observation, the surveyor observed the LPN remove the previous wound dressings. After discarding soiled dressings, the LPN performed hand hygiene and donned new clean gloves. The LPN proceeded to pack the sacral wound with the Dakin's soaked gauze. The LPN did not cleanse the wound site prior to packing. A 6x6 dressing was then applied over the wound. After changing gloves, the LPN then applied skin prep around the right ischial wound. The wound was then packed with the Dakin's soaked gauze. Again, the LPN did not cleanse the right ischial wound prior to packing. The LPN applied a 4x4 dressing over the right ischium. Interview was conducted on September 4, 2025 at 10:47AM with a LPN (Staff # 32), who stated that floor nurses and the wound care nurse can do wound care for residents. The LPN explained that the nurses should reference the physician orders to understand how to complete the wound treatments. She also stated that the wound nurse trains the floor nurses on how to complete wound care. Interview was conducted on September 5, 2025 at 9:48AM with the Director of Nursing (DON/Staff #72), who stated that she expected her nurses to look at provider orders when doing wound care and to do the ordered treatment. The DON stated that she knew the surveyor had questions about the wound care observation conducted, and produced a typed statement, which she stated was from the wound care nurse (LPN #124). The statement was not signed or dated. The DON, referencing the statement, stated that Dakin's solution did not require a wound to be cleansed prior, unless the wound was visibly soiled, as the Dakin's should stay on the wound. The statement also indicated that it was important to follow manufacturer recommendations for use. Despite the statement, the DON explained that every nurse gets education from the wound care nurse on how to (continued on next page)</p>		

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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>complete the treatments. Upon directing to the link provided on the wound care nurse's written statement, it was discovered that the link led to the Dakin's website on an article titled, Using Dakin's Solution During the Wound Healing Process: 3 Methods for Safe, Effective Healing. Review of this article revealed no evidence that the manufacturer suggested omitting cleansing a wound prior to packing the wound. Interview was conducted on September 5, 2025 at 11:15AM with the Wound Physician (MD/ Staff #320), who stated that nurses should follow the physician orders for wound care. The MD also explained that he would expect wounds to be cleansed at the time of assessment and treatment. He stated that he had told nurses that it is okay to use Dakin's solution instead of wound cleanser when cleansing a wound, but that wounds should definitely be cleansed prior to packing the wound. He further explained that he would expect the nurses to use one set of Dakin's soaked gauze to clean a wound, which would be discarded, and then use a separate set of Dakin's soaked gauze to pack the wound. The wound Physician felt that there may have been miscommunication with the wound nurse regarding the use of Dakin's solution. Review of the facility policy, Administering Medications revealed that all medications must be administered in accordance with the orders.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations, staff interview, and policy review, the facility failed to ensure staff were maintaining proper sanitary conditions by not wearing hair nets and facial hair guards during food preparation. The deficient practice could result in infection and or contamination of food. Findings include: A kitchen observation was conducted on September 02, 2025 at 8:10 a.m. Staff #107, cook, was observed in the kitchen without a hair net. Further, Staff #51, cook, was observed in the kitchen without a hair net and with facial hair present without wearing a beard guard/net. A small pot of a green substance resembling vegetables was observed to be boiling on the stove during this time. An interview was conducted on September 02, 2025 at 2:32 p.m. with Staff #125 (Food Service Director). Staff #125 stated that while working in the kitchen staff were required to wear hair nets and facial hair guards. Staff # 125 stated that failure to wear hair nets and facial guards can cause a risk of hair in the food. Regarding staff not wearing hair nets or facial hair guards during food preparation food service director stated, Yeah, they know better. An interview was conducted with Staff #5 (Administrator). Staff #5 stated that the expectations were that the facility policy are followed in order to prevent cross contamination in the kitchen. Further, Staff #5 stated he wanted staff to be safe and follow policy and procedure. Staff #5 stated that the expectations were to have staff follow policy and procedure, wash hands, keep everything clean. Food clean, storage clean, preparation of food orderly. Hand washing protocols followed. During food prep, the proper PPE should be donned including hair nets and facial hair covers are expected to be used while preparing food in the kitchen for the residents, cleanliness, and cross contamination purposes. Staff #5 stated that the risks included cross contamination of bacteria or any other substance that is unhealthy for the resident to consume. An interview was conducted September 05, 2025 at 11:08 a.m. with Staff #125 (Food Service Director). Staff #125 was informed that during the initial kitchen observation, a boiling pot of green vegetables was observed on the stove. He was asked what was in the pot. He replied that it was buttered spinach. It is started early in the day for slow cook or else it would burn. Buttered spinach was then verified on the menu as a lunch time item for service on September 02, 2025. A review of policy titled Personal Hygiene and Health Reporting from Chapter 4: Sanitation and Infection Control 4-7 from Nutrition Alliance, LLC revealed that all food and nutrition services employees will be trained on appropriate personal hygiene and health reporting. Further, Procedure 2.B states that hair should be kept neat and clean. Hair restraints must be worn around exposed foods, in the kitchen or food service areas and dining areas. Further, Procedure 2.C states that beards and mustaches should be closely cropped and neatly trimmed. When around exposed foods, beards must be restrained using beard covers.</p>		