STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035085	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Saguaro Valley	6651 East Carondelet Drive Tucson, AZ 85710

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911 Based on clinical record review, staff interviews, and facility documentation and policy review, the facility failed to ensure bowel and bladder care was provided for one resident (#3) out of 3 sampled. The deficient practice could result in skin breakdown and possible formation of pressure ulcers. Findings include: Resident #3 was admitted on [DATE] and discharged on [DATE] with diagnosis including essential hypertension, major depressive disorder-recurrent, peripheral vascular disease, paroxysmal atrial fibrillation, occlusion and stenosis of the left carotid artery, benign prostatic hyperplasia without urinary tract symptoms, pressure induced deep tissue damage of the sacral region and anxiety disorder. A review of the 5-day MDS (minimum data set) dated September 15, 2024 revealed a BIMS (brief interview of mental status) score of 10, indicating moderate cognitive impairment. A review of the care plan revealed a focus area of bladder incontinence due to impaired mobility. The interventions included use of disposable briefs and that these were to be checked and changed as needed, as well as an unobstructed path to the bathroom. A review of the facility tasks under bowel and bladder revealed that the resident was changed only once during day shift on September 14, 2024 at 3:05 P.M., September 15, 2024 at 5:30 P.M. and September 21, 2024 at 1:13 P.M. An interview was conducted on March 11, 2025 at 5:16 P.M. with CNA (certified nursing assistant, staff #56). The CNA stated that assigned tasks are documented in PCC (point click care) under the heading of POC (plan of care)/ tasks. She further stated that if tasks were not documented by the end of the shift then they did not occur. She stated that CNA's have to document each shift for each care area. The CNA stated that bowel and bladder care had to occur at least once per shift but often times more frequently. She stated that in general this is for almost every resident for changing and repositioning. She stated that her expectation is to respond to each resident's needs immediately and that if residents are soiled they should not have to wait. She stated that the risk for not changing a resident timely could include bed sores. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on March 11, 2025 at 5:21 P.M. with RN (registered nurse, staff #1). The RN stated that CNA's document the assigned tasks in PCC under the POC tab and that this would include bowel and bladder care. The RN stated that if the area was left blank, then this would indicate that the task wasn't done. She stated that the expectation is that assigned tasks are done and documented. The RN stated that the risk to the resident could be skin breakdown. An interview was conducted on March 11, 2025 at 5:31 P.M. with the DON (director of nursing, staff #41). The DON reviewed the POC task entries for bowel and bladder and stated that the documentation for bowel and bladder care was not consistent. The DON was unable to find any evidence in the resident's record supporting that bowel and bladder care had occured for the missing bowel and bladder entries on the POC. She stated that risk would be that the bowel and bladder care did not occur if it was not documented and that there could be a potential for skin breakdown. A review of the facility policy entitled Urinary Continence and Incontinence-Assessment and Management with a revision date of January 1, 2024 revealed that assessments for urinary continence include review of the resident's history, observations, cognitive limitations, and type of physical assistance required. The policy further notates that nursing staff, as part of a resident's assessment, will document details related to continence to include voiding patterns, pain or discomfort and types of incontinence. The policy also notes that incontinence care is individualized at night in order to maintain comfort and skin integrity. A review of the policy entitled Charting and Documentation, revised April 2008 revealed that all observations, medications administered, and services performed must be documented in the resident's clinical record.