STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035093	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Cottonwood	197 South Willard Street Cottonwood, AZ 86326

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48932 Based on clinical record review, interviews, observations, policy review and the State Agency (SA) complaint tracking system, the facility failed to ensure that two residents (#1 and #2) received treatment and care in accordance with professional standards of practice by failing to provide wound care as ordered by a physician. The sample size was 5. The deficient practice could lead to residents acquiring wound infections. Findings include: Resident #1 was admitted to the facility on [DATE] with diagnoses that include osteoporosis, acute post-hemorrhagic anemia, and chronic obstructive pulmonary disease (COPD). A review of a Minimum Data Set (MDS) assessment dated [DATE], indicated resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Review of the physician's orders revealed resident #1 was to have wound care by cleaning the Right surgical area with normal saline, pat dry, and apply dressing at the surgical site once a day every three days. Review of a weekly skin assessment dated [DATE] at 12:31 PM noted that resident #1 had a surgical dressing on the right lower leg with instructions in place until November 22. After that time, the dressing would need to be changed every three days. A review of the November 2024 Medication Administration Record (MAR) revealed, that between November 19, 2024 and November 30, 2024, wound care was provided three times (November 20, 23, and 30). A review of the December 2024 MAR revealed, that between December 1, 2024 and December 4, 2024, wound care was provided once (December 3, 2024) by staff #18. An interview was conducted with resident #1 on December 4, 2024 at 12:40 PM in her room. The resident indicated the wound bandage had not been changed in five day and she was not sure if the wound was getting better. She also indicated that the nurse was supposed to change it every few days. (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 - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on December 4, 2024 at 12:57 PM with Registered Nurse (RN/Staff #63). Staff #63 confirmed that she was the wound care nurse for the facility. She explained that her responsibility was to see residents, who receive wound care, once a week and to document in the skin assessments. Staff #63 continued to explain that she sees resident #1 once a week and when she last saw the resident, there were no concerns with her wounds. Staff #63 indicated that she last changed resident #1's wound bandage on November 29, 2024 and had not yet seen her since that date. Staff #63 also added that resident #1 often tells her that her bandage has not been changed in a week so she would go and change her bandage to make her happy. On December 4, 2024 at 1:54 PM, the [NAME] President of Clinical Operations (VP/Staff #9) was observed exiting resident #1's room. At that time, Staff #9 was asked to return to the resident's room with the State Surveyor (SS). Resident #1 was observed to be sitting on her wheelchair with a bandage exposed on her lower right leg. When asked what the date was on the bandage, Staff #9 responded November 29. When asked what that would indicate to the staff member, Staff #9 explained that she would have to look at the orders but it told her that the dressing was last changed on November 29, 2024. RN Staff #63 reached out to SS on December 2, 2024 at 2:21 PM. She explained that she took a look at resident #1's wound bandage and that the date on there was November 29, 2024. When asked what that mean, staff #63 stated that it meant she was the last person to change the bandage and that was on November 29, 2024. When asked what the risks to the resident would be if bandages are not changed as ordered, Staff #63 indicated that wound could potentially get infected. An interview was conducted with RN/Staff #18 on December 4, 2024 at 2:25 PM. Staff #18 confirmed that he worked on December 3, 2024 and that he sometimes provides wound care to residents. Staff #18 explained that when he provides wound care, he documents it on the MAR. When asked if he provided wound care to resident #1 on December 3, 2024, he stated that he did not. SS showed staff #18 the December MAR and asked him if he had signed off on wound care for resident #1. He looked at the MAR and explained that he did sign off on it but he did not provide the care as he thought he might have gotten distracted. When asked what the risks were if wound care is not provided to the resident as ordered, he indicated that if one wound care was missed, nothing would happen but if it were to be missed frequently then the wound could get infected. Related to resident #2: Resident #2 was admitted to the facility on [DATE] with diagnoses of osteomyelitis of vertebra, sacral, and sacrococcygeal region, type 1 diabetes, and cellulitis of both the right and left lower limb. Review of the last completed MDS, dated [DATE], did not have a completed BIMS assessment, however it was noted that the staff assessment for mental status was modified independence. Review of physician's orders found an order dated November 8, 2024 for wound care to the right ankle. The order indicated the wound was to be cleansed with saline, apply calcium alginate to wound and cover with clean dry dressing every three days and as needed. The December MAR was reviewed and it was noted that wound care to the right ankle was provided on December 3, 2024 by staff #18. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On December 4, 2024 at 2:58 PM, Resident #2 was observed with a bandage with blood soaked through on his right ankle. Licensed Practical Nurse (LPN/Staff #17) was present in the room when the observation was made and indicated that the date on the bandage was November 28 and that told her that the bandage was needing to be changed. Staff #17 explained that she had just come onto the floor as they recently did a shift change and that the outgoing nurse had told her that resident #2 needed a bandage changed because the nurse was not able to get to it during her shift. An interview was conducted on December 4, 2024 at 4:38 PM with staff #9. When what could be a possible risk to the residents if wound dressings are not changed as ordered by a provider. Staff #9 indicated there could be a possible infection of the wound. When asked what transpired with Resident #1 and Staff #9 explained that SS had made a true observation that her wound dressing was not changed,. Staff #9 continued to explain that the dressing should have been changed according to the schedule and it had not. She also indicated that the MAR showed that it was signed off but the actual care was not done. Staff #9 added that staff were not to be documenting care until it was provided. The policy titled, Skin/Wound Management: Wound Care was reviewed on December 4, 2024. The policy went into effect on January 1, 2024. The policy stated that the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. The documentation section of the policy indicated that the date and time the wound care was given should be recorded in the resident's medical record. This indicated that documentation was to be done after providing wound care. The policy titled, Documentation: Charting and Documentation stated All services provided to the resident . shall be documented in the resident's medical record,. The policy also indicated that documentation in the medical record will be complete and accurate.