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	02/27/2025

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** 51124 Based on clinical record review, staff interviews, and facility policy, the facility failed to ensure that a resident received care and services according to physician orders regarding weight monitoring for one resident (#10). The deficient practice could result in a residents not receiving treatment to meet their needs. -Findings include: Resident #10 was admitted on [DATE], with diagnoses that included hemiplegia and hemiparesis following cerebral infarction, dysarthria, dysphagia, acute respiratory failure with hypoxia, and methicillin susceptible staphylococcus aureus infection. A care plan dated February 1, 2025, revealed that the resident was at risk for nutritional problems with an intervention to monitor weights per orders. A physician order dated February 1, 2025, indicated for an enteral feed of Osmolite 1.5 to start at 35 ml/hr to increase by 10 ml/r until goal of 65 ml/hr and 90 ml of free water flushes every 2 hours. A physician order dated February 1, 2025, indicated for Weekly Weights: On admission and then follow facility protocol of weekly x 4 weeks. An admission Minimum Data Set (MDS) assessment dated [DATE], revealed a brief interview for mental status (BIMS) score of 4 indicating the resident had severely impaired cognition. Section GG revealed the resident was dependent on caregivers for oral and personal hygiene, toileting, dressing, bed mobility, transferring from sitting to standing, and transfers from bed to chair. The resident was unable to ambulate. Section I revealed the resident had malnutrition or was at risk for malnutrition. Additionally, the resident had a feeding tube. The medication and treatment administration record for February 2025 revealed no evidence of weekly weights taken. The Weights Summary log revealed one entry: -2/3/2025: 182.9 Lbs, taken on a standing scale, entered by a dietary consultant (Staff #6). (continued on next page)

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	The facility logs of weekly and monthly weights for February 1-February 17, 2025 were reviewed, with no evidence of any weights taken for Resident #10. Review of the Certified Nursing Assistant (CNA) Task log for Weights revealed no evidence that the resident refused any weights taken. A Nurse Practitioner progress note dated February 17, 2025, revealed patient with mouth breathing and work of breath not relieved by O2 and that the resident was sent to higher level of care. A Discharge Summary dated February 17, 2025, revealed the resident was transferred to the emergency department. An interview was conducted on February 27, 2025, at 10:50 AM with a CNA (Staff #12), who stated that the facility's process for taking residents' weights was that the facility has hoyer lift scales and wheelchair scales that a wheelchair can be rolled up on. Staff #12 also stated that a resident could walk up onto the wheelchair scale and be weighed that way. Staff #12 further clarified that a resident could not just stand up on the wheelchair scale, that several steps would need to be taken by the resident to be able to get on the scale. The CNA stated that the CNAs or nurses are the ones that take the residents' weights, that it is charted in the electronic medical record in a Weights log. Staff #12 stated that if a resident refuses to have a weight taken, then that would be documented as a refusal under the Weights Task log. A telephonic interview was conducted on February 27, 2025, at 11:28 AM, with a Registered Dietician (RD / Staff #19), who stated that she had been consulted to review Resident #10's tube feed order, to ensure that the resident was getting enough calories. The RD stated that the order was for the resident to start at 35 ml/hour and go up to 65 ml/hour. She stated that she uses the weight measurements that the facility has entered in the medical record to determine the resident's caloric needs, and that if there are no weights entered, that she will review the hospital records. The RD stated that she recalled a nursing director contacting her to review the resident's tube feed prescription because the resident's mouth was dry. A telephonic interview was conducted with a dietary consultant (Staff #6) on February 27, 2025, at 11:50 AM. The dietary consultant stated that all the work that she does with the facility is remote, that she does not come to the facility. She stated that if she notices that a resident does not have a weight assessment completed, that she will look in the past medical records from the discharging hospital and enter in the most recent weight she can find into the medical record. She stated that this is intended to be a place holder weight until the facility can get the weight assessment done. Staff #6 stated that if the facility did not weigh a resident, then it would not trigger any weight changes, and the resident may get missed for review. Staff #6 stated that there would be risks if the resident did not get weighed, and that the facility needed to establish a baseline weight, and monitor for weight gains or weight losses. Regarding Resident #10, the dietary consultant confirmed that she did not weigh the resident, rather that she entered a previously taken weight from the hospital into the medical record. An interview was conducted with a CNA (Staff #20) on February 27, 2025, at 12:33 PM, who stated that it is the CNAs who are in charge of getting resident weights. Additionally, the CNAs document the weights on a piece of paper that notifies them which residents need to be weighed, and then enter the weight into the medical record during their shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On February 27, 2025, at 12:34 PM, an interview was conducted with another CNA (Staff #31) who stated that CNAs are given paper lists of which residents need to be weighed, both weekly and monthly. An interview was conducted with the Director of Nursing (DON / Staff #3) on February 27, 2025, at 1:43 PM, who stated that she has been the DON at the facility for two days. She stated that the staff follow the facility policy for monitoring residents' weights. She additionally stated that it was her expectation that staff would follow physician orders for weight monitoring. The clinical record of Resident #10 was reviewed together and the DON confirmed that the resident had a weight monitoring order to be weighed weekly for four weeks. The DON also confirmed that only one weight was entered in the medical record which was the weight entered by the dietary consult (Staff #6), and that she would have to speak with staff to see what happened. An additional interview was conducted at this time with the former DON and current clinical resource (Staff #29), who stated that it looked like staff missed getting Resident #10's weight, and that it would not meet her expectation. Staff #29 stated that there are risks of missing residents' weight assessments: there could be potential weight loss for the residents or that the facility would not identify weight loss in a timely manner. Staff #29 stated that the facility would be taking steps to correct the issue. Review of the facility policy titled Nutrition/Hydration: Weight Assessment and Intervention, dated January 1, 2024, revealed that resident weights are monitored for undesirable or unintended weight loss or gain. Residents are weighed upon admission and at intervals established by the interdisciplinary team. Weights are recorded in the individual's medical record.