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	03/26/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124 Based on clinical record review, staff interviews, and facility documentation and policy review, the facility failed to ensure the medical record was complete, accurate, and readily accessible for one resident (#55). The deficient practice could lead to care team members not having accurate, complete, and current resident information to coordinate care, which could lead to a decreased quality of care for residents. -Findings include: Resident #55 was admitted [DATE], and readmitted [DATE], with diagnoses that included encounter for surgical aftercare following surgery on the genitourinary system, urinary tract infection, functional quadriplegia, depression, anxiety disorder, post-traumatic stress disorder, and conversion disorder. An admission MDS (minimum data set) assessment dated [DATE], revealed the resident had a BIMS (brief interview for mental status) score of 12, indicating the resident had moderately impaired cognition. A care plan dated February 18, 2025 for the resident experiencing impacts of distressing or traumatic events had interventions that included refer to mental health professional for trauma assessment and treatment. A Progress Note dated March 9, 2025, revealed the resident's physical and mental status seems to have changed since coming back from the hospital. The resident is no longer showing any signs of being a quadriplegic, and is now transferring herself from bed to wheelchair without any assistance. The resident is bringing random items from her room into the main room, and has been removing rocks from the plantar and placing them around the facility. Additionally, the resident has been taking towels, using them, and placing them in garbage bags, and putting the bag in the nursing cart garbage. The Director of Nursing (DON) and provider were notified. Staff tried to remove any items from her room that could harm her. A History and Physical note from the resident's medical provider dated March 9, 2025, indicated to consult the psychiatric (psych) provider for Resident #55. (continued on next page)

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
	035093	A. Building B. Wing	03/26/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Behavior Note dated March 10, 2025, revealed Resident #55 was awake all night long self-transferring and going to the water/coffee area, getting cups of water, and taking one sip and throwing the full cup of water away. Resident used up the entire bucket of water and a lot of cups every time. The resident was talking in the third person. Resident kept wheeling herself around the entire building as fast as she could. A Behavior Note dated March 12, 2025, revealed the resident was observed taking other resident's food apart and trying to feed him. The resident was asked not to do that and educated on the importance of asking certified nursing assistants (CNAs) and nurses for help. An additional Behavior Note dated March 14, 2025, revealed the resident had multiple episodes of crying and yelling at staff, and would start yelling at staff that she had needs, but then was unable to verbalize her needs and states she just wants to be taken care of and feel better. Staff provided emotional support and active listening. A Discharge Summary note dated March 17, 2025, revealed the resident left the facility against medical advice. There was no evidence in the clinical record that a psych provider was consulted for Resident #55, or that the resident was evaluated, or what interventions were recommended by a psych provider. A Medical Records Progress Note dated March 26, 2025, at 11:39 AM, revealed Resident #55 had a telehealth visit with the contracted psych provider on March 11, 2025. A call was placed to the provider on March 14, 2025 to request the visit notes. A follow up call was made on March 26, 2025, at approximately 11:00 AM to request the records. A Medical Records Progress Note dated March 26, 2025, at 1:44 PM, revealed the psych provider records had been received and uploaded into the resident's electronic medical record. An interview was conducted with a CNA (Staff #19) on March 26, 2025, at 10:48 AM. The CNA stated that she is in charge of scheduling appointments for the facility. Staff #19 stated that she was familiar with Resident #55, and that the resident started demonstrating behaviors when she returned from the hospital. Staff #19 stated that the resident was referred to a contracted psych provider, and was set up for a telehealth appointment on Monday, March 10, 2025. The CNA stated that she assisted the resident with setting up the electronic device for the telehealth appointment, but was not present for the resident's appointment visit. An interview was conducted on March 26, 2025, at 10:56 AM, with the Medical Records Manager (Staff #30), who stated that she had called the contracted psych provider for Resident #55's appointment visit notes, however had still not received the medical records. Staff #30 stated that she will re-request the records. (continued on next page)

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	03/26/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the DON (Staff #72) on March 26, 2025, at 12:51 PM. The DON stated that the importance of having a complete medical record for a resident would be for the facility to track incidences and occurrences regarding that resident's care, and additionally to allow the interdisciplinary team (IDT) to ensure care is completed and followed-up appropriately. If the medical record was not complete for a resident, the DON stated that this could negatively impact different aspects of residents' care and services. The clinical record for Resident #55 was reviewed at this time, and the DON stated that there was no evidence of any psych consultations or visit notes. The DON stated that this would still meet her expectation, because the facility had reached out to the psych provider to receive those notes. An interview as conducted with the [NAME] President of Clinical Operations (Staff #41) on March 26, 2025, at 1:53 PM. Staff #41 stated that the facility has no policy specifying a required time frame of when consults and visit notes need to be uploaded into the medical record. Review of the facility policy titled Charting and Documentation, dated January 1, 2024, revealed that all services provided to the resident, progress toward the care planned goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the IDT members regarding the resident's condition and response to care. Review of the facility policy titled Medical Records: Retention of Medical Records, dated January 1, 2024, revealed medical records shall be retained by the facility in accordance with current applicable laws. Review of federal regulation 483.70 (i) revealed a facility must maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized. Medical records must be retained for the period of time required by State law; or five years from the date of discharge when there is no requirement in State law. The medical record must contain a record of the resident's assessments, the comprehensive plan of care and services provided, and physician, nurse, and other licensed professionals progress notes.