

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  Haven of Cottonwood		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51124</p> <p>Based on observation, interviews, review of the clinical record, and review of facility policy and procedure, the facility failed to ensure one resident (#2) was provided care and services to meet professional standards regarding following physician orders for assessment of a resident post-fall. The deficient practice could lead to an injury being missed and a delay of care provided to a resident.</p> <p>-Findings include:</p> <p>Resident #2 was admitted to the facility January 10, 2025, and readmitted to the facility on [DATE], with diagnoses that included pneumonia, end-stage renal disease, acute pulmonary edema, hemiplegia and hemiparesis affecting the left side, and dysarthria.</p> <p>An admission MDS (minimum data set) assessment, dated January 16, 2025, revealed the resident had a brief interview for mental status (BIMS) score of 12, indicating the resident had moderately impaired cognition.</p> <p>A physician order dated March 4, 2025, indicated for an x-ray of Resident #2's right arm to rule out a fracture.</p> <p>A progress note dated March 4, 2025, revealed a Certified Nursing Assistant (CNA) called the nurse to the resident's room stating that the resident had rolled out of bed. The resident stated that he rolled out of bed and hit his right arm and back. The resident reported having mild discomfort. Additionally, the resident was having difficulty moving the right arm over his head. The provider was notified, and a new order for an x-ray was placed.</p> <p>An eMar-Medication Administration note dated March 5, 2025, revealed no xray this date regarding the right arm x-ray.</p> <p>Review of the clinical record revealed no evidence that the right arm x-ray was completed.</p> <p>A Progress Note dated April 2, 2025, revealed the provider was made aware that the resident's x-ray was not completed, and that there were no new orders.</p> <p>An interview was conducted on April 2, 2025, at 3:49 PM, with the Medical Records Manager (Staff #20), who stated that there was no x-ray for Resident #2.</p> <p>(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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NAME OF PROVIDER OR SUPPLIER  Haven of Cottonwood		STREET ADDRESS, CITY, STATE, ZIP CODE  197 South Willard Street Cottonwood, AZ 86326	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with a Licensed Practical Nurse (LPN / Staff #35) on April 2, 2025, at 4:11 PM. Staff #35 stated that the facility's process for getting an x-ray is that staff receives an order from the provider, that it is printed out and sent to a mobile x-ray company. Then, the mobile x-ray company is called, and the x-ray is scheduled. The clinical record was reviewed at this time, and Staff #35 stated that the x-ray for Resident #2's right arm was not done, and that she believed she made an error when she charted that the x-ray was not done on March 5, 2025, as the order goes away once it is charted on. Staff #35 stated that she just found out today that if an order is charted on, then it disappears.</p> <p>An interview was conducted with the Director of Nursing (DON / Staff #15) on April 3, 2025, at 10:15 AM. The DON stated that staff should follow physician orders as they are entered, and that if physician orders are not followed, that depending on the order, it could cause a delay of care, or a resident not receiving what is ordered. The DON stated that Resident #2 has had 2 falls during his admission to the facility, and that an x-ray for the right arm was ordered on March 4, 2025. The DON stated that it was brought to her attention yesterday that Resident #2 did not get the x-ray, and that it was a documentation issue from the floor nurse. The DON stated that the nurse was provided education on the issue, and that the provider was notified that the resident did not get the x-ray as ordered.</p> <p>Review of the facility policy titled Medication Orders, revised November 2014, revealed that a current list of orders must be maintained in the clinical record of each resident. Treatment orders must specify the treatment, frequency, and duration of the treatment.</p> <p>Review of the facility policy titled Medications: Documentation of Medication Administration, dated January 1, 2024, revealed a medication administration record is used to document all medications administered, and that administration of medication is documented immediately after it is given.</p>		