

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/31/2026
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)		
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** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure one of ten sampled residents (Resident #25) received prescribed anticoagulant medication, apixaban, in accordance with professional standards of practice when the medication was documented as self-administered without the required assessment, order, or care plan. The census was 72. The deficient practice could result in complications related to not receiving the prescribed medication. Findings include: Resident #25 was readmitted to the facility on [DATE], with diagnoses of esophageal obstruction, dysphagia, pulmonary hypertension, chronic systolic heart failure, paroxysmal atrial fibrillation, atherosclerotic heart disease, and the presence of cardiac and vascular implants and grafts. The hospital's Post-Acute Facility Orders, dated June 14, 2026, revealed an unchanged order for apixaban 2.5 MG (Milligram) by mouth twice daily with no indication that the medication was to be self-administered. A physician's order dated June 14, 2026, revealed an order for apixaban 2.5 MG by mouth twice daily for prevention of blood clots. The order contained directions for unsupervised self-administration. However, the clinical record revealed no evidence that Resident #25 had received an assessment or evaluation determining that the resident could safely self-administer medications. The record also contained no evidence of a care plan addressing medication self-administration. A physician's administrative order dated June 14, 2026, documented that a complete drug regimen review had been conducted upon admission and that no clinically significant medication issues were identified. The June 2026 Medication Administration Record (MAR) revealed that apixaban 2.5 MG was documented as U-SA, which was defined as unsupervised self-administration, for 17 total administrations from June 14, 2026, through June 22, 2026. A Medicare 5-Day Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident #25 had intact cognition. The MDS also revealed that the resident had an active diagnosis of dysphagia, esophageal obstruction, and cognitive communication deficit. An order audit report revealed that on June 23, 2026, the apixaban order was revised to change the administered by status from administered by status from unsupervised self-administration to clinician. A progress note dated June 23, 2026 at 12:30 p. m., by the Director of Nursing (DON), documented that the DON spoke with resident #25's daughter regarding concerns with apixaban. The note stated that the concerns were addressed and that there were no other concerns at that time. The note did not identify the specific concern regarding apixaban or document how the concern was addressed. An interview was conducted on July 31, 2026, at 8:09 a.m. with a Licensed Practical Nurse (LPN/Staff#9), who stated that a resident permitted to self-administer medications should have an order and a care plan for medication self-administration and that an assessment should be completed prior to the order. The LPN stated that a resident with dysphagia would not be able to self-administer medications without an order, Care plan, and evaluation by the interdisciplinary team (IDT). The LPN (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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