STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035094	A. Building B. Wing	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Sedona	505 Jacks Canyon Road Sedona, AZ 86351

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** Based on observation, interviews, review of records, and review of facility policy and procedure, the facility failed to ensure the medical record was accurate and complete for one resident (#2). The deficient practice could lead to care team members not being aware of a resident's status and lead to a delay in care or missed treatment. Findings Include: Resident #2 was admitted to the facility on [DATE], with diagnoses that included unspecified dementia, pulmonary fibrosis, type 2 diabetes mellitus, insomnia, anxiety disorder, and depression. An admission minimum data set (MDS) assessment dated [DATE], revealed the resident had a brief interview for mental status (BIMS) score of 8, indicating moderate cognitive impairment. A physician order dated February 21, 2025, indicated to complete a skin check weekly. A Weekly Skin Check and Wound assessment dated [DATE], revealed the resident had no new or ongoing skin impairments. An Alert Charting note dated April 27, 2025, revealed at around 2:15 PM, Resident #2 was found by a Certified Nursing Assistant (CNA) on the floor beside his bed. The resident was very much confused, and may have tried to get out from his bed as the resident is used to being independent when ambulating. The resident had been reported to have a change in condition since the previous shift. An Alert Charting note dated April 27, 2025, revealed that the nurse received an order from the provider on call to send Resident #2 out to the hospital for further evaluation post-fall for possible urinary tract infection and cellulitis on left arm. Paramedics came at 3:45 PM and took the resident to the hospital. A physician order dated April 30, 2025, indicated to send the resident out to the emergency department to rule out possible infection. The clinical record was reviewed, and revealed no evidence of any nursing assessment with description of a skin condition on the resident's left arm. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on May 12, 2025, at 1:20 PM, with a CNA (Staff #59), who stated that if a CNA were to notice a resident to have a new skin condition, that it would be reported to the nurse to assess. Staff #59 stated that he had observed Resident #2 to have an inflamed and purple-looking area on the resident's arm, and that he did not report it to the nurse because everybody knew about it. Staff #59 also stated that the resident was scratching and picking at it. A telephonic interview was conducted with a Registered Nurse (RN / Staff #36) on May 12, 2025, at 1:52 PM. Staff #36 stated that she recalled Resident #2, and that there was a red and swollen area on the resident's left arm. Staff #36 stated that on April 26, 2025, the day before the resident was sent out to the hospital, she had noticed that the skin condition had started, and that there was an open area on the resident's arm, and that it was not as swollen as the following day. On April 27, 2025, Staff #36 stated that the area on the resident's arm was more swollen, and that the resident kept trying to touch it, so Staff #36 then treated the arm and wrapped it. Staff #36 stated that another nurse called the provider, and Staff #36 was instructed to just observe the skin condition on Resident #2's arm. Later that day, Staff #36 stated that she was called by the provider, and instructed to send the resident to the hospital. An interview was conducted with a Unit Manager and Licensed Practical Nurse (LPN / Staff #70) on May 12, 2025, at 2:21 PM. Staff #70 stated that the facility's process if a new skin issue or rash is found on a resident would be to document it, to notify the Director of Nursing, notify the wound team, and to follow the provider's orders. Staff #70 stated that the last day that she worked in the facility before Resident #2 was sent out to the hospital was April 24, 2025, and that she had returned to work on April 28, 2025. The clinical record of Resident #2 was reviewed together, and Staff #70 stated that she had completed the Weekly Skin Assessment, dated April 27, 2025, that indicated that Resident #2 had no new or ongoing skin issues. Staff #70 also stated that she was not working in the facility on the day of April 27, 2025, and that she had completed the skin assessment the following date after the resident had already gone to the hospital. Staff #70 stated that there was no nursing assessment or description of the resident's left arm skin condition in the medical record. Staff #70 stated that I don't see there was anything inappropriate done, and that it was found there was a scratch on his arm and he was sent out to the hospital that day. A telephonic interview was conducted with the Director of Nursing (DON / Staff #42) on May 12, 2025, at 2:48 PM, who stated that her expectation for nurses is that assessments are completed timely and that if they are late, then nurses should do a late entry and document for the time that the assessment was actually done. The DON stated that it would be inappropriate for a nurse who did not actually look at a resident's skin to document an assessment, and to date it inaccurately. Review of the facility policy titled Documentation: Charting and Documentation, effective January 1, 2024, revealed all services provided to the resident, progress toward the care plan 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 interdisciplinary team regarding the resident's condition and response to care. Documentation of procedures and treatments will include care-specific details, including: the date and time the procedure/treatment was provided; the name and title of the individual(s) who provided the care; the assessment data and/or any unusual findings obtained during the procedure/treatment; how the resident tolerated the procedure/treatment; whether the resident refused the procedure/treatment; notification of family, physician or other staff, if indicated; and the signature and title of the individual documenting. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Assessments/Care Planning: Resident Examination and Assessment, effective January 1, 2024, revealed the purpose of this policy is to examine and assess the resident for any abnormalities in health status. Notify the physician of any abnormalities such as, but not limited to: abnormal vital signs; change in cognitive, behavioral or neurological status from baseline; wounds or rashes on the resident's skin; and worsening pain, as reported by the resident. The following information should be recorded in the resident's medical record: the date and time the procedure was performed, the name and title of the individual(s) who performed the procedure, all assessment data obtained during the procedure, how the resident tolerated the procedure if the resident refused the procedure, the reason(s) why and the intervention taken, and the signature and title of the person recording the data.