

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: 035127	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Haven Health Prescott, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 864 Dougherty Street Prescott, AZ 86305	
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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, staff interviews, and policy review, the facility failed to ensure that current nurse staffing data was accurate and posted at the beginning of the day. This deficient practice could result in residents and visitors not being informed of accurate, up-to-date nurse staffing data. The universe was 52. Findings Include: On July 19, 2026, at 10:22 AM, an observation of the facility's nursing staff posting revealed the posted staffing information was dated July 14, 2026, and reflected a resident census of 57. The current date was July 19, 2026, and the facility census was 52 residents, indicating the required daily staffing information had not been updated for five days. During an interview on July 22, 2026, at 9:55 AM, the Assistant Director of Nursing (ADON/Staff #94) stated the facility's process is to update and post the daily nursing staffing information each day. Staff #94 stated she is responsible for updating the posting during the week but does not update it on weekends because she is not in the facility. Staff #94 described the process used to verify daily staffing, including confirming the schedule with the lead Certified Nursing Assistant (CNA), visually verifying staff present, and reviewing the nursing staffing whiteboard. Staff #94 acknowledged that the staffing posting being five days out of date did not meet facility expectations and stated residents and visitors would not have access to current staffing information. During an interview on July 22, 2026, at 10:07 AM, the Director of Nursing (DON/Staff #73) stated the facility's process is to update and post nursing staffing information at the beginning of each day, including weekends. Staff #73 acknowledged the posting had not been updated for five days, accepted responsibility for the oversight, and stated the outdated posting did not meet facility expectations. Staff #73 further stated residents and visitors would not have access to accurate daily staffing information. A review of the facility policy, Personnel/Staffing: Posting Direct Care Daily Staffing Numbers, last revised January 1, 2024, revealed the facility will post daily nurse staffing information for each shift in a prominent location accessible to residents and visitors. The policy further requires that, within two hours of the beginning of each shift, the numbers of Registered Nurses (RNs), Licensed Practical/Vocational Nurses (LPNs/LVNs), Certified Nursing Assistants (CNAs), and Nursing Assistants (NAs) providing direct resident care be posted in a clear and reusable format.		

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, staff interviews, and review of facility policy, the facility failed to ensure one medication cart was secured in accordance with facility policy. This deficient practice created the potential for unauthorized access to medications, medical supplies, and protected health information. The sample was one medication cart. The facility census was 52 residents. Findings Include: On July 22, 2026, at approximately 7:49 a.m., an observation was conducted in the hallway adjacent to the nurses' station. A medication cart was observed unlocked and unattended with no nursing staff present. The drawers faced the hallway, the back of the cart was against the wall, and the cart's locking mechanism indicated it was unlocked. While the cart remained unsecured, an environmental services staff member walked past at approximately 7:54 a.m., followed by three additional staff members at approximately 7:57 a.m. Licensed Practical Nurse (LPN/Staff #53) walked past the unsecured cart at approximately 7:58 a.m. Three Certified Nursing Assistants (CNAs) walked past at approximately 8:04 a.m. At approximately 8:05 a.m., two residents and one CNA passed the cart. At approximately 8:09 a.m., LPN/Staff #115 approached the unattended cart and locked it. At approximately 8:27 a.m., LPN/Staff #53 opened the drawers of the previously unsecured medication cart, revealing medications and medical supplies stored inside. During an interview on July 22, 2026, at approximately 8:09 a.m., LPN/Staff #115 stated the medication cart was unlocked and unattended when he approached it and that he locked it after discovering it unsecured. He stated facility policy required medication carts to be locked whenever they are not in use and that leaving the cart unsecured could allow unauthorized access to medications or resident information. During interviews conducted on July 22, 2026, the Director of Nursing (Staff #73), LPN/Staff #53, and the Administrator (Staff #15) each confirmed facility policy required medication carts to remain locked whenever unattended or not actively in use. Staff identified potential risks of an unsecured medication cart, including unauthorized access to medications and medication theft. LPN/Staff #53 confirmed she had been assigned to the medication cart observed unsecured that morning. Review of the facility policy, R009 - Pharmacy Services: Security of Medication Cart, Version 051123, revealed medication carts must be securely locked at all times when out of the nurse's view. The policy further states that when a medication cart is not in use, it must be locked and parked at the nurses' station or inside the medication room.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and policy review, the facility failed to ensure food items were stored in accordance with professional standards for food service safety. This deficient practice had the potential to increase the risk of foodborne illness. The census was 52. Findings Include: During an initial kitchen observation conducted on July 19, 2026, at approximately 9:45 AM, accompanied by the Dietary Aide (Staff #50), several strawberries stored in the large walk-in refrigerator were observed to have visible discoloration consistent with mold. During an interview at the time of the observation, Staff #50 stated the strawberries looked really bad and confirmed the discoloration was mold. Staff #50 stated the condition of the strawberries did not meet facility expectations and acknowledged that serving spoiled fruit could result in residents becoming ill. On July 22, 2026, at 9:48 AM, the Dietary Manager (Staff #91) confirmed the strawberries were moldy and should have been discarded. Staff #91 stated kitchen staff are expected to conduct daily visual inspections of refrigerated food items and dispose of any food showing signs of spoilage or mold. Staff #91 acknowledged that failure to discard spoiled food could result in residents becoming ill. On July 22, 2026, at 11:11 AM, the Administrator (Staff #15) stated the facility's expectation is that any fruit exhibiting discoloration, mold, or other signs of spoilage be discarded immediately. Staff #15 stated the condition of the strawberries did not meet facility expectations and acknowledged the potential for resident harm, including gastrointestinal illness. A review of the facility policy titled Food Storage revealed it is the facility's policy that food items be stored, thawed, and prepared in accordance with good sanitary practices. The policy further states that expired, outdated, or spoiled food products are to be discarded.		

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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 interviews, review of clinical record, and review of facility policy and procedure, the facility failed to ensure the medical record was accurate and complete regarding skin assessments for one resident (#28). The deficient practice could result in interdisciplinary team members not being aware of a resident's status.-Findings include:Resident #28 admitted to the facility on [DATE], with diagnoses of ground level fall with trimalleolar fracture of the right ankle, right ankle fusion, hypertension, type 2 diabetes mellitus, coronary artery disease, chronic kidney disease, chronic obstructive pulmonary disease, cerebrovascular accident with right hemiparesis, and hypertension.A physician's order dated April 18, 2026, was for an orthopedic surgery appointment on April 30, 2026, at 10:00 a.m.A Weekly Skin Check and Wound assessment dated [DATE], revealed the following skin issues:-Coccyx: non-blanchable redness to coccyx-Scattered bruising to bilateral upper extremities-Rash under right breast-Surgical site on the right lower extremity wrapped with ace bandage, and cam boot in placeA physician's order dated April 22, 2026, revealed wound care to the right leg, to cleanse with wound cleanser then apply xeroform to surgical incisions x3, and to wrap with rolled gauze and secure with ACE wrap, every day shift for displaced trimalleolar fracture of right lower leg.A Weekly Skin Check and Wound assessment dated [DATE], revealed the following skin issues:-Coccyx: non-blanchable redness to coccyx-Scattered bruising to bilateral upper extremities-Rash under right breast-Surgical site on right lower extremity: surgical incisions x 3, and sutures to lateral lower leg and heelThe documentation included no evidence of wound measurements.A Weekly Skin Check and Wound assessment dated [DATE], revealed the following skin issues:-Coccyx: non-blanchable redness to coccyx, and noted to see pressure injury documentation-Scattered bruising to bilateral upper extremities-Redness under right breast-Surgical site on right lower extremity: surgical incisions x 3, and sutures to lateral lower leg and heel.The documentation included no evidence of measurements or other wound descriptions.Documentation (undated) from Resident #28's orthopedic appointment visit, uploaded into the electronic medical record (EMR) on April 30, 2026, included physician orders which revealed that Resident #28's sutures were removed, and that it was ok for the resident to shower. Additionally, the orders included to paint the wound with betadine, cover with dry padded gauze, and ace wrap.An admission minimum data set (MDS) assessment dated [DATE], revealed Resident #28 had a Brief Interview for Mental Status (BIMS) assessment score of 15, indicating intact cognition. Section M: Skin Conditions revealed Resident #28 had one unhealed stage 2 pressure ulcer present upon admission.A Weekly Skin Check and Wound assessment dated [DATE], revealed the following skin issues:-Coccyx: non-blanchable redness to coccyx, and noted to see pressure injury documentation-Scattered bruising to bilateral upper extremities-Redness under right breast-Surgical site on right lower extremity: surgical incisions x 3. Despite the orthopedic visit note uploaded April 30, 2026, revealing that the resident's sutures were removed, the skin assessment revealed the resident had sutures to the lateral lower leg and heel, and a small blister to dorsal foot and lateral ankle.Additionally, the documentation included no evidence of measurements or further wound descriptions.A physician's order dated May 13, 2026, revealed wound care to right leg, to cleanse with wound cleanser then apply xeroform to blister on dorsal ankle, and to apply AG and foam dressing to heel incision, to wrap with rolled gauze and secure with loosely fitting ACE wrap, every day shift for wound care related to displaced trimalleolar fracture of right lower leg.A Weekly Skin Check and Wound assessment dated [DATE], revealed the following skin issues:-Coccyx: non-blanchable (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	redness to coccyx, and noted to see pressure injury documentation-Scattered bruising to bilateral upper extremities-Redness under right breast-Surgical site on right lower extremity: surgical incisions x 3. Despite the previous documentation that the resident's sutures were removed, the skin assessment continued to reveal that the resident had sutures to the lateral lower leg and heel, and a small blister to dorsal foot and lateral ankle. The documentation included no evidence of measurements or further wound descriptions.An SW-Skin Issues assessment dated [DATE], revealed Resident #28 had an improving stage 2 pressure ulcer / injury on the buttocks that was present on admission. The documentation included no evidence of any wound or skin issue on the resident's right heel, dorsal foot, or lateral ankle.An SW-Skin Issues assessment dated [DATE], revealed Resident #28 had a stable stage 2 pressure ulcer / injury on the buttocks that was present on admission. Additionally, the documentation revealed Resident #28 had a new skin issue located on the middle of the left heel (despite the evidence that the resident's ankle surgery was performed on the right ankle). Further, despite the SW-Skin issues assessment dated [DATE], revealing no evidence of a heel wound, the documentation revealed that the left heel wound was a surgical wound and was acquired in-house on May 14, 2026. The documentation revealed that the incision was not approximated, showed signs of non-healing, increased size, and increased exudate. The exudate was moderate, purulent, and with odor. The size of the wound was 4.2 cm wide x 4.1 cm deep x 0.2 cm deep. The documentation included no measurements or descriptors of a right dorsal foot blister or lateral right ankle blister.A Weekly Skin Check and Wound assessment dated [DATE], revealed the following skin issues:-Coccyx: non-blanchable redness to coccyx, and noted to see pressure injury documentation-Scattered bruising to bilateral upper extremities-Redness under right breast-Surgical site on right lower extremity: surgical incisions x 3. Despite the previous documentation that the resident's sutures were removed, the skin assessment revealed the resident had sutures to the lateral lower leg and heel, and a small blister to dorsal foot and lateral ankle. Further, the assessment did not include any evidence of a left or right heel wound documented on the SW-Skin Issues progress note dated May 21, 2026. Also, the documentation included no evidence of measurements or further wound descriptions.A physician's order dated May 22, 2026, revealed wound care to right leg, to cleanse with wound cleanser then apply xeroform to blister on dorsal ankle, and then apply AG with silver to heel and foam sheet outside of gauze wrap, and to wrap with rolled gauze and secure with loosely fitting ACE wrap, every day shift for displaced trimalleolar fracture of right lower leg.A Weekly Skin Check and Wound assessment dated [DATE], revealed the following skin issues:-Coccyx: non-blanchable redness to coccyx, and to see pressure injury documentation-Scattered bruising to bilateral upper extremities-Redness under right breast-Surgical site on right lower extremity: surgical incisions x 3. The skin assessment revealed the discrepancy that the resident had sutures to the lateral lower leg and heel. The documentation included the resident had a small blister to the dorsal foot and lateral ankle. The assessment revealed no evidence of a left or right heel wound. Additionally, the documentation revealed no evidence of measurements or further wound descriptions.An SW-Skin Issues progress note dated May 28, 2026, revealed Resident #28 had a surgical wound located on the middle of the left heel (despite evidence that the resident had a right ankle surgery), acquired on May 14, 2026. The documentation revealed the size of the wound was 4.0 cm wide x 4.0 cm deep x 0.1 cm deep, and that the exudate was light, serosanguinous, and with no odor. Additionally, the assessment revealed Resident #28 had an improving stage 2 pressure ulcer / injury on the buttocks that was present on admission. The documentation included no measurements or descriptors of a right dorsal foot blister or lateral ankle blister.A Health Status note dated May 31, 2026, revealed the wound to the resident's right foot appeared to be deteriorating, increasing in size, (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and with mild purulent exudate and foul odor. The note included the provider was notified, and orders were received for antibiotic medication and an x-ray of the right lower extremity. A physiatry progress note dated June 1, 2026, revealed the resident had a ground-level fall with a trimalleolar fracture of the right ankle, status post ankle nailing procedure and right ankle fusion surgery. The note revealed the resident reported pain in the right heel, with drainage from infection, and that the resident was treated with antibiotics. The assessment revealed a right heel surgical site infection with mild purulent exudate and foul odor, and a right heel wound culture positive for staph aureus. The plan included to continue clindamycin (antibiotic) for 14 days, and to follow up at the wound care clinic. A provider encounter note dated June 1, 2026, revealed that over the weekend, nursing noted increased drainage from Resident #28's heel. The plan included to obtain laboratory results, to continue antibiotics for 14 days, to follow up with the wound care clinic, and the resident may discharge when arrangements were completed. The note revealed that the resident would be discharging home with her spouse. An eMAR (electronic Medication Administration Record) note dated June 2, 2026, revealed Resident #28 was discharged. A wound care clinic progress note dated June 4, 2026, revealed that Resident #28 presented to the wound care clinic with wounds to the right lower extremity / foot after a right ankle fracture and surgical repair on April 9, 2026, after which the resident was then transferred to the facility where she was admitted for approximately 2 months. The note revealed that while at the facility, Resident #28 developed multiple wounds on the right lower extremity and foot. An interview was conducted with a licensed practical nurse / wound nurse (LPN / Staff #115) on July 22, 2026, at 9:21 a.m. who stated that the facility's process for identifying and monitoring wounds in the facility was upon admission, each resident would receive a skin assessment completed by the floor nurse, and then Staff #115 would also complete his own skin assessment directly afterward, to ensure no skin issues were missed. Then, Staff #115 stated that he would monitor skin issues and wounds by completing a weekly skin assessment. Staff #115 stated that if a resident had a pressure ulcer or a surgical wound, then that would be assessed and documented in the SW- Skin Issues assessment, which was completed weekly. Staff #115 stated that the skin assessment would include wound measurements, wound descriptors, and presence of any exudate and odors, which would be important to identify a wound's progress or deterioration, or presence of infection. Staff #115 stated that if he noted any signs of deterioration or infection, he would notify the provider for consultation. Staff #115 stated that a risk to a resident if documentation were incomplete or inaccurate would be that the provider may not know the exact status of the wound, and that the documentation may not provide a clear picture of what was going on with the resident's condition. Regarding Resident #28, Staff #115 stated that the resident admitted to the facility with 3 surgical wounds on her right lower extremity, that were initially healing well, until it was noted that there was exudate coming from the back of the right heel surgical site. Staff #115 stated that the resident's sutures were removed during her orthopedic appointment on April 30, 2026. Staff #115 reviewed the clinical record, and stated that the right heel surgical wound was noted to be opening on May 14, 2026, and that there was no documentation of any measurements or descriptors of the wound. Staff #115 stated that he believed the wound was approximately 2 cm x 2 cm at that time. Staff #115 reviewed the SW Skin Issues assessment dated [DATE], and stated that the wound was approximately 4 cm x 4 cm. Additionally, Staff #115 reviewed the weekly skin assessments completed in May 2026, and stated that the documentation of the resident having sutures in the right lower extremity was not accurate. Staff #115 stated that if another clinician or provider reviewed the resident's weekly skin assessments completed in May 2026, it would not paint a clear picture of the status of the resident's right lower extremity wounds. An interview was conducted on July 22, 2026, at 12:10 p.m. with the Director of (continued on next page)		

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