STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035139	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Show Low	2401 East Hunt Street Show Low, AZ 85901

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, review of the clinical record, and review of facility policy and procedure, the facility failed to ensure one resident (#18) was provided care and services, according to professional standards and physician orders, to prevent a new pressure ulcer and prevent worsening of existing pressure ulcers. The deficient practice could lead to physical harm of residents developing new or worsening wounds. -Findings Include: Resident #18 was initially admitted to the facility September 25, 2019, with diagnoses that included hyperlipidemia, chronic kidney disease, diastolic heart failure, neuromuscular dysfunction of bladder, ulcer of anus and rectum, and localized edema. A quarterly minimum data set (MDS) assessment dated [DATE], revealed the Resident #18 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident had intact cognition. Section GG revealed the resident was dependent on staff for bed mobility of sit to lying, and required substantial/maximum assistance with rolling in bed. Additionally, the resident had a diagnosis of paraplegia. A care plan dated May 24, 2021, revealed the resident was at risk for skin impairment, and had pressure ulcers on bilateral gluteal folds and sacrum, and a rectal fistula. Interventions included to assess/record/monitor wound healing weekly and as necessary. Measure length, width, and depth where possible, assess and document status of wound perimeter, wound bed, and healing progress. Report improvements and declines to the physician. If the resident refuses treatment, confer with the resident, interdisciplinary team (IDT), and family to determine the cause and try alternative methods to gain compliance. Document alternative methods. There was no evidence of a care plan update for a facility-acquired pressure ulcer on the resident's scrotum. A physician order dated August 28, 2024, and discontinued September 4, 2024, indicated to cleanse left ischium with Dakins, pat dry, apply calcium alginate, cover with ABD pad, and secure with tape, change daily and as needed, and notify provider of any concerns, two times a day every Mon, Wed, Fri, and Sun. A duplicate order indicated for two times a day every Tue, Thu, and Sat, and was also discontinued September 4, 2024. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	There was no evidence of wound care orders or treatment for the left ischium wound from September 4, 2024 until November 1, 2024. A physician order dated August 28, 2024, and discontinued November 1, 2024, indicated for wound care: cleanse sacral ulcer with WCS, pat dry, sprinkle collagen powder to wound bed, apply Maxorb Ag, cover with ABD pad and secure with tape, two times a day every Mon, Wed, Fri, and Sun. An additional duplicate order dated August 29, 2024, indicated for two times a day every Tue, Thu, and Sat. A physician order dated August 28, 2024, and discontinued November 1, 2024, indicated for wound care: cleanse right ischium with Dakins, apply Maxorb Ag and ABD pad, change two times a day every Mon, Wed, Fri, and Sun. A duplicate order indicated for two times a day every Tue, Thu, and Sat. A physician order dated October 25, 2024, indicated to clean wound with normal saline, pat dry, pack wound with 1/4 inch put ABD wrap with kerlix every night shift for wound care. There was no evidence of which wound the treatment was indicated for. A Pressure Ulcer Documentation assessment dated [DATE], revealed the resident had three pressure ulcers: -Right gluteal fold pressure ulcer, present on admission, Stage 4, measured as 3.2 x 0.8 x 1.2 cm, no tunneling -Left gluteal fold pressure ulcer, present on admission, Stage 4, measured as 2.2 x 2.3 x 0.7 cm, no tunneling -Sacral pressure ulcer, present on admission, Stage 4, measured as 2.0 x 2.3 x 0.6 cm, no tunneling Wound Care Visit Discharge Instructions dated September 3, 2024, revealed the resident had wounds on the right and left ischium, sacrum, and peri-anus. Discharge instructions included: -Right and Left Ischium: cleanse wound with wound cleaner, change ABD pad dressing 3 times per day and as needed -Midline Sacrum: cleanse wound with wound cleaner, change ABD pad and Maxorb Ag dressing 3 times per day and as needed -Peri-anus: cleanse wound with wound cleaner, change ABD pad dressing 3 times per day and as needed A Weekly Skin Check and Wound assessment dated [DATE], revealed the resident had right and left gluteal fold pressure ulcers, and a sacral pressure ulcer. There was no evidence of measurements or further details of the wounds. A Pressure Ulcer Documentation assessment dated [DATE], revealed the resident had four pressure ulcers: -Right gluteal fold pressure ulcer, present on admission, Stage 4, measured as 1.9 x 0.7 x 0.4 cm (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Left gluteal fold pressure ulcer, present on admission, Stage 4, measured as 2.5 x 0.5 x 1.5 cm, tunneling noted with a depth of 1.6 cm -Coccyx pressure ulcer, present on admission, Stage 4, measured as 2.6 x 3.1 x 2.1 cm, tunneling from 12:00 to 3:00 noted with a depth of 2.1 cm -Scrotum, present on admission, Stage 4, measured as 2.7 x 1.6 x 0.5 cm A Pressure Ulcer Documentation assessment dated [DATE], revealed the resident had four pressure ulcers: -Right gluteal fold pressure ulcer, present on admission, Stage 4, measured as 2.5 x 3.1 x 1.4 cm -Left gluteal fold pressure ulcer, present on admission, Stage 4, measured as 2.5 x 0.5 x 1.5 cm -Coccyx pressure ulcer, present on admission, Stage 4, measured as 2.3 x 3.0 x 2.1 cm -Scrotum, facility-acquired with an onset date of September 23, 2024, Stage 4, measured as 2.7 x 1.6 x 0.5 cm There was no evidence of documentaion on the presence of tunneling on any of the wounds. The clinical record was reviewed and there was no evidence of notification to the physician of the new facility-acquired scrotum wound, or any treatment orders. Additionally, there was no evidence of any weekly wound assessments, including measurements or descriptions of the pressure wounds, between September 26 - October 14, 2024. A Pressure Ulcer Documentation assessment dated [DATE], revealed the following: -Coccyx pressure ulcer, present on admission, Stage 4, measured as 2.3 x 3.0 x 0.5 cm -Right gluteal fold pressure ulcer, with the measurement left blank and no descriptors -Pressure Ulcer #3: no evidence of location or any measurement or descriptors A Weekly Skin Check and Wound assessment dated [DATE], revealed the resident had right and left gluteal fold pressure ulcers, a coccyx pressure ulcer, and a medial testicular pressure ulcer. There was no evidence of measurements or further details of the pressure ulcers. Review of the MAR for September 2024 revealed there was no right ischium and sacral wound care treatment completed either shift on September 11, 13, and 15, and the clinical record revealed there was no evidence of the resident refusing the missed wound care treatments. A Medication Administration Note dated September 23, 2024, revealed the resident did not want to lay down to have wounds measured at the time. There was no evidence that alternatives were coordinated with the resident. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The MAR for October 2024 and the clinical record were reviewed, and the resident missed sacral and/or right ischium wound care treatments for the following reasons, with no evidence of coordination of alternatives per the care plan: -October 9: refused -October 10; resident was up in chair, and at dialysis -October 12: at dialysis -October 14: had visitors -October 15: refused, and at dialysis -October 19: up in chair for dinner -October 22: at dialysis -October 23: refused -October 27: refused -October 28: refused -October 29: up in wheelchair A Discharge Summary note dated November 5, 2024, revealed the resident was transferred to the hospital via ambulance for difficulty breathing. A physician progress note from the hospital admission dated November 12, 2024, revealed the resident was treated for sepsis present on admission secondary to sacral wound, pneumonia, and urinary tract infection. Additionally, sacral decubitus wound with a wound culture positive for Proteus mirabilis. The resident was treated with antibiotics. An interview was conducted with a Registered Nurse, (RN / Stff #50) on April 16, 2025, at 1:09 pm, who stated if a treatment is ordered every shift, then it should be completed at some time during the shift, for day shift and night shift. Staff #50 stated that she was familiar with Resident #6, and that he had pressure wounds on the buttocks and sacral area. Staff #50 reviewed the clinical record and stated that the resident had orders for weekly skin and wound assessments. Staff #50 also reviewed the gap in weekly assessments from September 26 - October 14, 2024, and stated that the impact on a resident of missing the weekly asssssments could be worsening wounds, missing new wounds or onset of infection. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On April 16, 2025, at 1:35 PM, an interview was conducted with an RN / unit manager (Staff #96), who stated if a treatment is ordered every shift and as needed, then the treatment should be done anytime during that shift as well as any additional times that are needed. Staff #96 stated that if a treatment was not completed as ordered, then the resident's condition could worsen. Additionally, Staff #96 stated that if a resident was ordered weekly skin checks, then the nurse should complete the assessment and document in the weekly skin assessment. Also, if a resident was not assessed weeekly as ordered, then the wound could worsen or become infected and lead to delayed care. Staff #96 stated she was familiar with Resident #6 and that he had wounds on the hips and coccyx. The clinical record was reviewed and Staff #96 stated that there's a week missing in there for the weekly skin assessments between September and October 2024. Additionally, the missing sacral wound care treatments from September 2024 were reviewed in the record, and Staff #96 stated that there was no documentation that the treatments were done on September 11, 13, and 15. An interview was conducted with the Director of Nursing (DON / Staff #48) on April 16, 2025, at 2:52 PM. The DON stated that if a treatment is ordered every shift then it should be completed during that shift. If a resident was at a dialysis appointment, or was in a wheelchair and did not wanted to be treated at that particular time, then the nurse should communicate with the resident to find an alternate time to provide the treatment, or if it was at the end of the shift to communicate to the next shift that the treatment was not done so that the next nurse could address it. The DON stated that she was aware that Resident #6 had pressure ulcers to the coccyx and right and left buttocks, and that she was notified that the resident had bleeding from the scrotum but when assessed, did not see a pressure ulcer on the scrotum. The clinical record was reviewed and the DON stated that she could not see any evidence of notifiction to the provider for the documented new onset of the scrotal pressure ulcer. The missing weekly wound assessments for September-October 2024 and the missing wound care treatments were reviewed together and the DON stated this would not meet her expectation and that the facility had already been taking steps to correct the issue. An interview was conducted with the [NAME] President of Clinical Operations (Staff #4) on April 16, 2025, at 3:17 PM. Staff #4 stated that for residents with pressure ulcers, at least once a week, the wound size and descriptors should be documented. Staff #4 stated that the oucome for Resident #6 was that although the resident had a guarded condition and several comorbidities, that there were some missed wound treatments and a newly acquired pressure ulcer. Staff #4 stated that within the past several months, it was identified by the facility that there were issues in the wound care of Resident #6 and that corrective steps were taken such as partnering with a new wound provider. Review of the facility policy titled Assessments/Care Planning: Care Plans, Comprehensive Person-Centered, dated January 1, 2024, revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Review of the facility policy titled Assessments/Care Planning: Change in a Resident's Condition or Status, dated Janaury 1, 2024, revealed the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical condition, need to alter the resident's medical treatment significantly, refusal of treatment two (2) or more consecutive times, and/or specific instruction to notify the physician of changes in the resident's condition. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy titled Assessments/Care Planning: Resident Examination and Assessment, dated January 1, 2024, revealed the purpose of this policy is to examine and assess the resident for any abnormalities in health status, which provides a basis for the care plan. The assessment process shall be systematic, comprehensive and multidisciplinary based on the individual resident's needs, acuity and priorities in accordance with physician orders. Orders are to be completed in accordance with physician orders determined at a resident's time of admission or throughout the resident stay. A change in order for assessment is based upon the resident's acuity at the time of the order. Notify the supervisor if the resident refuses the examination. Notify the physician of any abnormalities, including but not limited to wounds or rashes on the resident's skin.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, review of the clinical record, and review of facility policy and procedure, the facility failed to ensure one resident (#6) was prevented from an accident of bleach ingestion. The deficient practice could lead to physical harm of residents, including serious illness and death. -Findings Include: Resident #6 was initially admitted to the facility May 1, 2021, with diagnoses that included Parkinson's disease, anxiety disorder, hypertension, obesity, and abscess of liver. An admission minimum data set (MDS) assessment dated [DATE], revealed the Resident #6 had a Brief Interview for Mental Status (BIMS) score that was dashed, indicating the assessment was not completed with the resident. There was no evidence of a care plan to address impaired cognition until July 12, 2023. A care plan was initiated this date for an alteration in neurological status due to metabolic encephalopathy/disease process, with interventions to cue and redirect as needed and give medications as ordered. A Daily Skilled Evaluation dated April 16, 2023, revealed Resident #6 wanders halls and occasionally attempts to go out the front door, and the resident is monitored while up in wheelchair. Daily Skilled Evaluations revealed the following: -March 10, 2023: the resident is oriented x 3. -March 11, 2023: the resident is oriented x 2. -March 15, 2023: the resident is oriented x 2. -March 17, 2023: All cares provided in resident's room due to COVID-19 isolation status, and the resident is oriented x 2. -March 18, 2023: the resident is oriented x 2. A Medication Administration Note dated May 18, 2023, revealed the resident is up all during the night and going into other resident's rooms. When trying to redirect him, the resident is grabbing the side rails and door frames, and is trying to go outside and setting off the alarm. The resident is trying to hit staff when being redirected. A provider Encounter Note dated May 20, 2023, revealed the resident is seen on May 21, 2023, for bleach ingestion. The resident is noted to have ingested bleach, and had put water in a container that had some bleach wipes in it and then drank that. Nursing staff had the resident drink about 750 cc of water. The resident appears asymptomatic. Nursing staff to push as much free water as possible, and continue to monitor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility Reportable Event Report dated May 22, 2023, revealed the administrator (Staff #26) was contacted by the nurse on duty for an incident on May 21, 2023, of potential bleach ingestion by Resident #6. During the investigation, the resident's BIMS score was re-assessed at 5, indicating severe cognitive impairment. Per the resident's roommate, the resident had filled a bleach wipe container with water, potentially ingesting the water after filling it. The resident was interviewed and gestured to a different water cup indicating he had mistaken the bleach container for his water cup, which was also located in the resident's room. Upon review of the incident, it was determined that the cleaning wipes were present in the resident's room. The staff were instructed to round on all other resident rooms to ensure other wipes containers were not accessible to residents. On April 16, 2024, a formal request was made to the facility for the facility's policy on chemical storage. The administrator signed a statement at 12:40 PM that the facility does not have a policy for chemical storage, that the facility follows the policy titled Resident Safety: Safety and Supervision of Residents. An observation was conducted on April 16, 2025, at 8:09 AM. In room [ROOM NUMBER], where a resident was laying in bed, a cleaning wipe container was observed on the shelf that was within reach from wheelchair level. An interview was conducted at this time with a Certified Nursing Assistant (CNA / Staff #31), who retrieved the cleaning wipe container from the room. The label of the container was read together. The CNA stated that the label had a warning that the product was harmful to humans. The CNA stated that cleaning wipe containers are supposed to be taken back to the nurse's station because they could be a hazard to residents. An interview was conducted on April 16, 2024, at 1:09 PM, with a Registered Nurse (RN / Staff #50) who stated that nurses assess the cognitive status of residents by asking orientation questions and documenting how many questions the resident got correct, and that would be documented as oriented x 1, x 2, or x 3. Staff #50 stated that the facility protects residents from hazardous chemicals by ensuring medications are not left at bedside and that chemicals should be stored in utility closets or janitor closets. The nurse stated that she did not believe it safe to leave hazardous chemical substances within access of a confused resident. An interview was conducted on April 16, 2025, at 2:52 PM, with the Director of Nursing (DON / Staff #48), who stated that the facility assesses resident's cognitive status by conducting the BIMS assessment to get a baseline, and that nurses assess the resident's orientation status. The DON stated that the facility keeps residents safe from hazardous chemical exposure by locking medications and that chemicals should be kept away from residents' rooms. The DON also stated that if a resident were to have access to harmful chemicals, then the resident could obtain it and have risk to the resident, and that it would not meet her expectation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Resident Safety: Safety and Supervision of Residents, dated January 1, 2024, revealed the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/ accident data; and a facility-wide commitment to safety at all levels of the organization. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in the resident's condition.