STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035169	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Highlands Care Center	1081 Kathleen Ave Kingman, AZ 86401

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(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 - Minimal harm or potential for 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** 49399 Based on closed clinical record review, staff and residents' interviews and policy review, the facility failed to ensure one resident (#2) was provided care and services to prevent pressure ulcers/injury from developing and/or worsening. The deficient practice could place resident at risk for developing and/or worsening of pressure ulcers/imjury. Findings include: Resident #2 was admitted to the facility with an initial admitted [DATE] with diagnoses of Pneumonia, Type 2 Diabetes Mellitus, acquired absence of left upper limb and amputation of two fingers of right hand. Review of nursing progress note titled, Skin Only, dated February 17, 2025 at 15:56 PM revealed that the resident had current skin issues. The progress note revealed resident had a healed skin post amputation of left forearm, and a scrotal excoriation which a barrier cream was ordered and initiated. Review of nursing progress note titled, Braden Scale for Predicting Pressure Ulcer Risk, dated February 17, 2025 at 19:26 PM revealed a Braden Evaluation result of 'At Risk' with a score of 18.0. Review of the wound nurse progress note dated February 17, 2025 revealed that the resident had a current skin issues which included healed wound from the amputation of left forearm, and an excoriation to scrotum which an order of barrier cream to be applied to the area was initiated, and the provider and resident/responsible party were notified. A review of order dated February 17, 2025 revealed an order for Calazinc to scrotum and buttocks with each brief change and as needed for skin integrity. However, review of resident's care plan did not reveal a care plan that resident had an excoriated scrotum area with an intervention. Review of February 2025 treatment administration record (TAR) revealed that Calazinc to scrotum and buttocks with each brief change and as needed for skin integrity every shift was transcribed in the TAR and was scheduled at 0700 AM and 1900 PM. The TAR revealed that the treatment was administered from February 17 through February 22, 2025. However, the February 2025 TAR revealed that the medication Calazinc was not accurately transcribed to show the as needed for skin integrity every shift medication administration. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of care plan dated February 17, 2025 revealed a risk for disturbed sensory perception. The goal is resident skin will remain intact. The interventions include to educate Resident/Representative on the importance of frequent position changes, evaluate Resident's ability to feel sensations, and evaluate skin for areas of blanching or redness. Review of facility's document titled, Monthly Shower Assistance Log, for the month of February 2025 revealed that the resident received a bed bath on February 17. Review of the nurse practitioner (NP) progress notes dated February 18, 2025 revealed an admission note. The progress note revealed that the resident received the initial therapy evaluation; nursing voiced no concerns; and skin is warm, dry, multiple pressure injuries present on admission; and continue current plan of care with specific adjustments/additions. The progress notes also revealed that due to the residents age and comorbidities resident is at increased risk for rapid decompensation with little to no warning. However, the NP progress note did not reveal location of pressure injuries and plan of care. Review of dietary/nutrition progress notes dated February 18, 2025 revealed food preferences, likes and dislikes, and current diet were discussed during the visit. Review of care plan dated February 19, 2025 revealed resident's current functional performance is related to impaired mobility. The interventions include resident requires extensive assist/two-person physical assist for bed mobility, toilet use, and transfers; and resident requires limited assist/one-person assist with dressing and personal hygiene. Review of the NP progress notes dated February 20, 2025 revealed a follow up visit. The progress note revealed active medication list, allergy list, past medical history, vital signs, code status, and general physical exam. The progress note revealed to continue current plan and current medications, and due to the residents age and comorbidities resident is at increased risk for rapid decompensation with little to no warning. However, the NP progress notes did not reveal notes relating to resident's pressure injuries and plan of care. Review of admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15.0 indicate intact cognition; behavior symptoms for rejection of care was not exhibited; resident requires partial/moderate assistance with rolling left and right and sit to lying; resident requires substantial/maximal assistance with chair/bed transfer, toilet transfer and shower transfer; always incontinent of bowels; resident admitted without pressure ulcers/injuries and was assessed at risk of developing pressure ulcers/injuries; and skin treatment includes turning/repositioning program and nutrition or hydration intervention to manage skin problems. Review of nursing progress note titled, Transfer to Hospital Summary, dated February 22, 2025 revealed Resident #2 appeared lethargic and was transported to the hospital via a non-emergent transport. Resident family and the NP were notified. Review of nursing progress note titled, Admission Summary, dated February 27, 2025 at 17:59 PM revealed Resident #2 readmitted to the facility. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of nursing progress note titled, Braden Scale for Predicting Pressure Ulcer Risk, dated February 27, 2025 at 19:32 PM revealed a readmission Braden evaluation result of at risk with a score of 18.0. Review of nursing progress note titled, Skin only, dated February 27, 2025 at 22:11 PM revealed a skin evaluation that revealed the resident has current skin issues which includes a non-pitting edema to the top of feet, and has a multi podus boot (MPB) in place to both feet. Review of the NP progress notes dated February 28, 2025 revealed a readmission note. The progress notes revealed skin is warm and dry, and decreased sensation to light touch to both feet. Resident blood albumin level result is 2.6 on February 28, 2025 and a SNP mashed potatoes ordered. The progress notes also revealed that due to the residents age and comorbidities resident is at increased risk for rapid decompensation with little to no warning. Review of progress notes revealed dietary visited resident on February 28, 2025. The progress notes revealed a discussion of resident's likes and dislikes, no change to preferences, and current diet. Resident prefers to eat in bedroom with small portions. Resident's current weight was 148.0 pounds by Hoyer lift. And, dietary will continue toencourage healthy intake. Furthermore, resident requested to have two- whole milk and a small order of mash potatoes and gravy for all meals. Review of facility's document titled, CNA Documentation, for the month of February 2025 revealed a task for repositioning for AM and PM from February 17 through February 21 and from February 27 through February 28. Review of the NP progress note dated March 3, 2025 revealed a progress note that resident is currently being seen for readmission, resident with no new complaints or concerns, and nurses report no new issues or concerns. The progress note revealed skin is warm, and without rashes. Review of nursing progress note titled, Braden Scale for Predicting Pressure Ulcer Risk, dated March 6, 2025 at 21:15 PM revealed a Braden evaluation result of At Risk with a score of 18.0. Review of the NP progress notes dated March 3, 2025 revealed no new complaints, concerns or issues from nurses. Review of NP progress notes dated March 4, 2025 revealed resident has requested physical therapy to work on standing, and it was ordered and communicated to the therapy department, including speech therapy for swallowing. The progress notes revealed that the resident denies any issues with choking though resident stated that sometimes has a difficult time with food that is not sof tand/or moist with a gravy or sauce. Review of diet order revealed an order for controlled carb diet, soft and bite size texture, regular/thin consistency. Review of nursing progress notes dated March 6, 2025 at 21:15 PM revealed a nursing progress note titled, Braden Scale for Predicting Pressure Ulcer Risk, revealed a Braden evaluation result of At Risk with a score of 18.0. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of nursing progress note titled, Skin Only, dated March 6, 2025 at 21:52 PM revealed Resident #2 has current skin issues. Resident has both of top of feet noted non-pitting edema and MPB in place for both feet, and has a sacral pressure ulcer/injury stage 2, which is described as open, red area pressure ulcer, and covered with a gel dressing. The progress note did not reveal that the provider or resident/family were notified of the pressure ulcer. The resident's care plan for skin integrity was not updated for having stage 2 sacral pressure ulcer/injury. Review of the wound nurse progress note dated March 11, 2025 at 07:02 AM revealed resident has current skin issues: - Unstageable sacrum Pressure Ulcer/Injury with the following description: Length: 7.1 Width: 7.0 Depth: 0.1 Wound bed: Slough. Wound exudate: Serous. Peri wound condition: within normal limits (WNL). Dressing saturation: Moderate (26-75%). Wound odor: No. Tunneling: No. Undermining: No. Tissue: Warm. Skin note: sacral wound 60% slough/40% granulation tissue. - Unstageable left gluteal fold Pressure Ulcer/Injury with the following description: Length: 1.0 Width: 1.3 Depth: 0.1 Wound bed: Slough. Wound exudate: Serous. Peri wound condition: WNL. Dressing saturation: Minimal (<25%). Wound odor: No. Tunneling: No. Undermining: No. Tissue: Warm. Skin note: left gluteal fold 100% slough. The progress notes also revealed that the provider was contacted. The resident/responsible party was made aware of the diagnosis and plan of care. Review of NP progress notes dated March 11, 2025 revealed a wound care consult visit type for new pressure injuries. The progress note revealed treatment orders provided, offloading with repositioning was discussed with resident, and a mattress overlay is on order. The progress notes also revealed that the resident informed the NP that his appetite has been improving and is eating more varied diet. In addition, the progress notes revealed that physical therapy and speech therapy are still pending. Furthermore, the nurse practitioner progress notes identified and described the following wounds/pressure injuries: -Wound 1: unstageable pressure wound located in the sacrum measuring 7.1 centimeter (cm) by 7.0 cm by 0. 1 cm with 60% slough, 40% granulation tissue, scant serous sanguineous exudate without odor, peri wound is intact. The treatment is to use normal saline or wound cleanser to be done daily and as needed with a primary dressing using Medihoney and a secondary dressing using an adhesive foam dressing. Additional order to offload per facility protocol, and a mattress overlay on order; -Wound 2: stage 3 pressure wound located in the left upper ischium measuring 0.4 cm by 0.4 cm by 0.2 cm without exudate or odor, peri wound intact. The treatment is to use normal saline or wound cleanser to be done daily and as needed with a primary dressing using Medihoney and a secondary dressing using an adhesive foam dressing. Additional order to offload per facility protocol, and a mattress overlay on order; and -Wound 3: unstageable pressure wound located in the left ischial tuberosity measuring 1.0 cm by 1.3 cm by 0.1 cm with 100% slough without exudate or odor and peri wound is intact. The treatment is to use normal saline or wound cleanser to be done daily and as needed with a primary dressing using Medihoney and a secondary dressing using an adhesive foam dressing. Additional order to offload per facility protocol, and a mattress overlay on order. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician progress notes dated March 11, 2025 revealed a follow-up of medical illness. The progress notes revealed that the resident is bedridden, currently is not receiving physical therapy, resident has not walked for some time. Nurses report no new issues or concerns. Resident's appetite and activity level are stable. Review of care plan initiated on March 12, 2025 revealed resident has an actual impairment to skin integrity of the sacrum related to unstageable pressure wound to sacrum. The interventions initiated on March 12, 2025 includes encourage good nutrition and hydration in order to promote healthier skin, follow facility protocols for treatment of injury, monitor/document location, size and treatment of skin injury, report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to medical doctor, and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Review of nursing progress notes titled, Skin Only, dated March 13, 2025 at 22:15 PM revealed a skin evaluation revealing resident has current skin issues. The progress notes revealed resident's buttocks has excoriation, and a skin protectant applied. However, there was no provider notification revealed in the progress notes. Review of the wound nurse progress note dated March 20, 2025 at 09:26 AM revealed resident has current skin issues: - Unstageable sacrum Pressure Ulcer/Injury with the following description: Length: 5.1 Width: 5.0 Depth:0.1 Wound bed: Slough. Wound exudate: Serous. Peri wound condition: Maceration. Dressing saturation: Moderate (26-75%). Wound odor: No. Tunneling: No. Undermining: No. Tissue: Warm. Skin note: sacrum 80% slough/20% granulation tissue with the peri wound maceration; and - Stage II - Partial thickness skin loss left gluteal fold Pressure Ulcer/Injury with the following description: Length:0.4 Width: 0.4 Depth: 0.2 Wound bed: Granulation. Wound exudate: Serous. Peri wound condition: WNL. Dressing saturation: Minimal (<25%). Wound odor: No. Tunneling: No. Undermining: No. Tissue: Warm. Skin note: left gluteal fold 100% granulation. The progress notes also revealed that the provider was contacted. The resident/responsible party was made aware of the diagnosis and plan of care. Review of NP progress notes dated March 20, 2025 revealed a wound care follow-up visit. The progress notes revealed that the resident was evaluated by therapy last week and therapy is pending per insurance approval. The progress notes revealed that the resident's pressure injuries have improved overall but have a new moisture associated skin damage (MASD) to his right buttock. Resident has reportedly been having frequent loose stools so Metamucil was ordered to help bulk up his stool as resident does not get much fiber in the diet. In addition, the NP progress notes included resident's wounds assessment: - Wound 1: Unstageable Pressure Ulcer in the Sacrum measuring 5.1 cm x 5 cm x 0.1 cm; has 80% slough, 20% granulation tissue; has scant serosanguinous exudate without odor; the peri wound is intact. The treatment is to use Wound Cleansing: normal saline (NS) or wound cleanser daily and as needed with a primary dressing using Medihoney and a secondary dressing using Adhesive foam dressing. Offload per facility policy and the mattress overlay is on order; (continued on next page)

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	035169	A. Building B. Wing	04/17/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Wound 2: Unstageable Pressure Ulcer in the Left upper ischium measuring 0.4 cm x 0.4 cm x 0.2 cm, base has 100% slough, no exudate, no odor, and the peri wound is intact. The treatment is to use Wound Cleansing: normal saline (NS) or wound cleanser daily and as needed with a primary dressing using Medihoney and a secondary dressing using Adhesive foam dressing. Offload per facility policy and the mattress overlay is on order; -Wound 3: Unstageable Pressure Ulcer in the Left ischial tuberosity measuring 0.8 cm x 0.9 cm x 0.1 cm, the base has 100% slough, the exudate is 20% granulation tissue, 80% slough without odor, peri wound is intact. The treatment is to use Wound Cleansing: normal saline (NS) or wound cleanser daily and as needed with a primary dressing using Medihoney and a secondary dressing using Adhesive foam dressing. Offload per facility policy and the mattress overlay is on order; and -Wound 4: MASD in the Right buttock measuring 5.0 cm x 5.0 cm x 0.1 cm, the base is pink, there is no exudate or odor, peri wound is intact. The treatment is to use Wound Cleansing: NS or wound cleanser with brief changes and a secondary dressing using barrier cream. Keep skin clean and dry. Offload per facility policy and the mattress overlay is on order. Review of March 2025 medication administration record (MAR) revealed Metamucil Smooth Texture Oral Powder give one tablespoon by mouth one time a day for bowel management, mix in eight ounces of water or juice was ordered on March 21, 2025, and the resident was administered the medication starting March 21, 2025 in the morning. Review of resident's care plan revealed no revision of care plan to include offloading per facility policy and mattress overlay. Review of care plan initiated on March 27, 2025 revealed resident refuses to turn in bed. The goal included resident will not develop new pressure wounds. The intervention dated March 27, 2025 includes resident will turn often in bed and to educate resident on importance of turning in bed for pressure relief. Review of NP progress notes dated March 27, 2025 revealed a wound care and nutrition follow-up visit. The progress notes revealed that the slough to the sacral pressure injury was softening and much of it was able to be debrided today with the resident's consent. The progress notes also revealed that the resident continues to refuse repositioning and offloading, and an alternating pressure mattress was ordered for pressure reduction and will be applied by tomorrow morning. In addition, the NP progress notes included resident's wounds assessment: -Wound 1: Unstageable Pressure Ulcer in the Sacrum measuring 5.5 cm x 5.6 cm x 0.5 cm, has an Undermining at 0300 to 0900 at 1.0 cm depth, the base has 80% slough, 20% granulation tissue, moderate Serosanguineous exudate without odor, peri wound is intact. The treatment is to use Wound Cleansing: normal saline (NS) or wound cleanser daily and as needed with a primary dressing using Medihoney and a secondary dressing using Adhesive foam dressing. Offload per facility policy and the mattress overlay is on order; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Wound 2: Unstageable Pressure Ulcer in the Left upper ischium measuring 1.0 cm x 0.8 cm x 0.1 cm, base has 100% slough, no exudate, no odor, and the peri wound is intact. The treatment is to use Wound Cleansing: normal saline (NS) or wound cleanser daily and as needed with a primary dressing using Medihoney and a secondary dressing using Adhesive foam dressing. Offload per facility policy and the mattress overlay is on order; -Wound 3: Unstageable Pressure Ulcer in the Left ischial tuberosity measuring 1.0 cm x 0.8 cm x 0.1 cm, the base has 100% slough, no exudate, no odor, and the peri wound is intact. The treatment is to use Wound Cleansing: normal saline (NS) or wound cleanser daily and as needed with a primary dressing using Medihoney and a secondary dressing using Adhesive foam dressing. Offload per facility policy and the mattress overlay is on order; and -Wound 4: MASD in the Right buttock measuring 2.0 cm x 2.0 cm x 0.1 cm, the base is pink, no exudate, no odor, and the peri wound is intact. The treatment is to use Wound Cleansing: NS or wound cleanser with brief changes and a secondary dressing using barrier cream. Review of the wound nurse progress note dated March 27, 2025 at 11:41 AM revealed resident has current skin issues: - Unstageable sacrum Pressure Ulcer/Injury with the following description: Length: 5.5 Width: 5.6 Depth: 0.9 Wound bed: Slough. Wound exudate: Serous. Peri wound condition: Fragile. Dressing saturation: Heavy (>75%). Wound odor: No. Tunneling: No. Undermining: Yes. Tissue: Warm. Skin note: sacrum 100% slough. The wound nurse progress notes revealed that the wound was debrided by the NP at bedside. The wound undermining is at the 0300-0900 with a 1.0 cm deepest aspect. Peri wound with maceration and excoriation noted. Review of care plan for actual impairment of skin integrity of the sacrum related to unstageable pressure wound to sacrum revealed a revised intervention dated March 28, 2025 that includes resident needs alternating pressure mattress (APM) to protect the skin while in bed. Review of physician orders dated March 11, 2025 revealed the following wound orders: - Sacral wound: Cleanse with wound cleanser, apply Medihoney, cover with Mepilex. Change dressing every day until resolved for skin integrity every day shift every Monday, Tuesday, Wednesday, Thursday, and Friday; and - Left gluteal fold: Cleanse with wound cleanser, apply iodosorb, cover with Mepilex. Change dressing every day for skin integrity every day shift every Monday, Tuesday, Wednesday, Thursday, and Friday. The application of iodosorb was not part of the treatment order revealed in the NP progress notes. Review of physician orders revealed an order for air mattress to bed for skin integrity check functioning every shift was ordered on March 14, 2025. Review of March 2025 TAR (Treatment Administration Record) revealed these orders were transcribed as: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Sacral wound: Cleanse with wound cleanser, apply Medihoney, cover with Mepilex. Change dressing everyday until resolved for skin integrity every day shift every Monday, Tuesday, Wednesday, Thursday, and Friday; - Sacral wound: Cleanse with wound cleanser, apply Medihoney, cover with Mepilex. Change dressing every day until resolved for skin integrity every night shift every Saturday and Sunday; - Left gluteal fold: Cleanse with wound cleanser, apply iodosorb, cover with Mepilex. Change dressing every day for skin integrity every day shift every Monday, Tuesday, Wednesday, Thursday, and Friday; - Left gluteal fold: Cleanse with wound cleanser, apply iodosorb, cover with Mepilex. Change dressing every day for skin integrity every night shifts every Saturday and Sunday; and -APM mattress to bed for skin integrity check function every shift was transcribed on March 28, 2025. Review of facility document titled, Monthly Shower Assistance Log, for the month of March 2025 revealed resident was provided bed baths on March 4, March 7, March 13, March 22, March 25, and March 30. The record revealed that the resident refused bed baths on March 17 and March 27. In addition, the document did not reveal any skin issues under comments. Review of facility's document titled, CNA Documentation, for the month of March 2025 revealed a task for repositioning for AM and PM for the whole month of March. Review of NP progress notes dated April 3, 2025 revealed a wound care follow-up visit. The progress notes revealed that the resident's MASD has resolved. However, according to the progress notes the resident's sacral pressure injury has increased in depth as the necrotic tissue continues to be debrided; slough was debrided again during today's NP's exam with the resident's consent. APM mattress is in bed, resident refuses additional repositioning to offload so the wound. The progress notes revealed that the wound healing remains difficult as the resident is always laying on his back in bed. Resident's blood sugars remained controlled. In addition, the NP progress notes included resident's wounds assessment: -Wound 1: Unstageable Pressure Ulcer in the Sacrum measuring 6.0 cm x 5.6 cm x 1.2 cm, has an Undermining at 0300 to 1200 at 3.0 cm depth, the base has 90% slough, 10% granulation tissue, small to moderate Serosanguineous exudate without odor, peri wound is intact. The treatment is to use Wound Cleansing: 1/4-strength Dakins soak for 15 minutes, then rinse with NS or wound cleanser daily and as needed with a primary dressing using AG rope and a secondary dressing using Adhesive foam dressing. Offload per facility policy and alternating pressure mattress in use; -Wound 2: Unstageable Pressure Ulcer in the Left upper ischium measuring 1.0 cm x 1.0 cm x 0.1 cm, base has 100% slough, no exudate, no odor, and the peri wound is intact. The treatment is to use Wound Cleansing: normal saline (NS) or wound cleanser daily and as needed with a primary dressing using Medihoney and a secondary dressing using Adhesive foam dressing; -Wound 3: Left ischial tuberosity status resolved, the base has 100% epithelialized, no exudate, and no odor; and (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Wound 4: MASD right buttocks resolved the base has 100% epithelialized, no exudate, and no odor. Review of facility's document titled, Weekly Skin Assessment, dated April 3, 2025 revealed a pressure ulcer on the coccyx area. Review of the wound nurse progress note dated April 3, 2025 at 16:07 PM revealed resident has current skin issues. The progress note revealed an unstageable sacrum Pressure Ulcer/Injury Stage with the following description: Length: 6.0 Width: 5.6 Depth: 1.5 Wound bed: Slough. Wound exudate: Purulent. Peri wound condition: within normal limits (WNL). Dressing saturation: Heavy (>75%). Wound odor: No. Tunneling: No. Undermining: Yes. Tissue: Warm. Skin note: sacrum 100% slough, undermining is at the 0300-1200 with 3.0 cm at deepest aspect. The wound nurse progress notes also revealed the wound was debrided by the NP at bedside, the resident tolerated the procedure well, Resident continues to refuse side to side repositioning, and the alternating pressure mattress (APM) is in the bed and functioning properly. Review of NP progress notes dated April 3, 2025 revealed a wound care follow-up visit. The progress notes revealed that the resident's nutrition remains poor; resident mainly been eating Spaghetti-os, resident continues to refuse repositioning or offloading of his sacral wound, and an alternating pressure mattress has been in use. The progress notes revealed that the distal portion of the wound opened yesterday and has been draining. Also, Dakin's has not been available for wound cleansing as it is on order so Vashe has been used. The progress notes also revealed that there is now a tunnel at the distal portion of the wound that is visible and appears to be going into the resident's rectum, and stool was present on exam of this area. Resident was sent to emergency department for further evaluation and treatment. In addition, the NP progress notes included resident's wounds assessment: -Wound 1: Unstageable Pressure Ulcer in the Sacrum measuring 7.0 cm x 5.7 cm x 1.5 cm with an undermining at 0300 to 1200 at 4.0 cm depth with a base consisting of 90% slough, 10% granulation tissue, has moderate Serosanguineous exudate without odor. The treatment is to use Wound Cleansing: 1/4-strength Dakins soak for 15 minutes, then rinse with NS or wound cleanser daily and as needed with a primary dressing using AG rope and a secondary dressing using Adhesive foam dressing. Offload per facility policy and alternating pressure mattress in use. Review of facility's document titled, Monthly Shower Assistance Log, for the month of April 2025 revealed resident received bed bath on April 3 and April 6. The document revealed no documentation of skin issues under comments. Review of facility's document titled, CNA Documentation, for the month of April 2025 revealed a task for repositioning for AM and PM from April 1 through April 10. Review of nursing progress titled, Incident Note, dated April 10, 2025 revealed the nurse practitioner requested the patient to be sent out to the emergency department due to the severity of the coccyx wound. Review of record revealed on April 10, 2025 resident was sent out to hospital for wound on coccyx. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035169	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Highlands Care Center	1081 Kathleen Ave Kingman, AZ 86401

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 - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on April 16, 2025 at 12:50 PM with a certified nursing assistant (CNA)/Staff #115 in the conference room. Staff stated that she works day shift, does the CNA schedule, help assist with daily activities on the floor such as showers, and feeding. Regarding scheduling, she stated that for enough staff, she schedules at least eight CNAs through the day, the CNA takes care of ten to fifteen residents, and could be less depending on their census. Regarding showers, the resident gets two showers a week. They have a shower book or binder, and for instance for Monday and Thursday shower is for odd numbered rooms and Tuesday and Friday showers are for the even numbered rooms. She stated that Wednesday, Saturday, and Sundays are the make-up shower days. She stated that they use a paper charting to document the resident showers, bed baths, or if the shower or bath is refused. She stated that during showers, if she notices anything on the skin she will notify the nurse. An interview was conducted on April 16, 2025 at 1:05 PM with CNA/Staff #32 in the conference room. She stated that showers are twice a week per resident and it gets charted in the shower book. She does computer charting for activities of daily living (ADLs) such as transfers, behaviors, bowel movements, and bladder continence. She stated that she does not have bed mobility charting in the computer and maybe the nurses do it but she does not. She is not familiar with resident #2 care. She stated that regarding skin issues such as a cut, bruise, not walking right detected during a shower, she will notify the nurse. An interview was conducted on April 16, 2025 at 1:31 PM with LPN/wound nurse/Staff #106. She stated that for wound care, when resident arrives in the facility, the facility NP/Staff #400 rounds on Thursdays for weekly updates. She performs wound treatments as ordered daily from Monday through Friday, and takes care of pressure ulcers wounds and surgical wounds. Staff stated that regarding resident #2, resident's wound was brought to her attention. Resident has on admission an excoriation to scrotum, and on March 6, a skin assessment was completed by Staff #89, who is a night shift nurse. In addition, she stated that one of the aid brought to her attention about resident's sacral wound, and so she assessed the wound and started treatment such as APM (alternating pressure mattress), daily dressing changes, the NP debrided the wound on April 3, and then resident was sent out on April 10 because there might be a fistula in the wound due to increased drainage, she had an impression that it was going in the bowel. She stated that resident was non-compliant with turning, resident needs assistance with turning/repositioning but resident refused. She stated that resident has a care plan for refusal to turn. However, review of care plan revealed resident's refusal to turn in bed was initiated on March 27, 2025. An interview was conducted on April 17, 2025 at 11:23 AM with NP/Staff #400 via phone interview. Staff stated that she works for the facility. She stated that regarding resident #2, she is in the facility weekly on Thursdays. She started seeing resident on March 11, 2025 for his wound. She was notified by wound nurse. She stated that resident had an unstageable pressure wound to sacrum and the left ischial have two to three stage III wound and unstageable. She saw resident the first time on March 11, 2025 related to the wound. She was originally seeing the resident for primary care for pulmonary embolism (PE), deep vein thrombosis (DVT) and diabetes management when first admitted on [DATE]. She stated that resident did not have any wounds. She stated that resident was sent out to the hospital for altered mental status and shortness of breath and was readmitted back in the facility at the end of February. She stated that she was not aware of any skin issues after resident was readmitted to the facility on [DATE]. She stated that the resident's sacrum wound was unstageable, was covered with necrotic slough, could not tell how deep it was. The treatment was Medihoney to get rid of slough and as a microbial, encourage to reposition resident but resident constantly wants t[TRUNCATED]