

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Haven of Douglas		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 North San Antonio Avenue Douglas, AZ 85607	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 facility policy review, the facility failed to ensure that food items were stored and prepared under sanitary condition; and failed to ensure that expired food items were discarded. The deficient practice could result in unsafe food storage, placing residents at risk for foodborne illnesses. Findings include: During an initial kitchen observation conducted with the dietary aide (staff #70) on August 5, 2025 at 10:25 a.m. there were undated and unnamed Styrofoam meal box of 2 bologna sandwiches, bag of shredded cheese dated July 29 to August 1, 2025, a container dated August 4, 2025 with a hard boiled egg and an open Ziploc bag with cheese dated August 2, 2025. The dietary aide (staff #70) stated that the facility use 2 days from the day the hard boiled was cooked because there is no use by date for hard boiled eggs. The dietary aide then threw the Styrofoam meal box away and stated that there was no name or date on the Styrofoam box. At 10:31 a.m., the observation of the dry storage was conducted with the Dietary Manager (staff #23). The following items opened and with no opened/used by dates and were found in the dry storage area: -1 bag of hot dog bun; and, -1 large tub of mayonnaise. There was also 1 large tub of BBQ sauce dated July 16, 2025; but, it was noted whether it was the opened date or the used by date. The dietary manager stated that date on the tub was the opened date; and, the barbecue sauce did not have a use by date. There was also a box containing 6-7 heads of cabbage with multiple brown areas on the outside of each cabbage. The dietary manager stated that they would cut these cabbage in half to see the inside, but would not serve this to residents. The dietary manager stated that staff know what food had expired and what food items were still good in the refrigerator; and that, first date on the containers was when the food was made, and the second date was the use by or expiration date. Inside the freezer, there was 1 Ziploc bag of marinara sauce that had an expiration date of July 9, 2025; and, 1 Ziploc bag of cooked ham with an expiration date of July 17, 2025. The dietary manager stated that both the marinara sauce and the bag of cooked ham were expired. During an observation of the puree meal preparation with the dietary manager (staff #23) conducted on August 6, 2025 at 11:09 a.m., there were multiple flies found in the kitchen area, on the wall near the entrance to the refrigerator, on the tray line serving area and on the drink preparation area. The Dietary Manger stated that the administrator was aware of the issue and was trying to find a solution to the problem; however, the dietary manager does not know what the solution was. Further, the dietary manager stated that kitchen staff will kill the flies then wipe off the area where the fly was killed. An interview was conducted on August 7, 2025 at 8:50 a.m. with Infection Preventionist (IP/Staff #63), who stated the population served had an average age of 65, with weakened immune systems and age-related changes in the digestive system; and, it was very important that food was procured, stored, prepared, and served in sanitary conditions to prevent residents from becoming sick. Further, the IP stated that hand hygiene of kitchen of staff was important to prevent the spread of infection. The IP stated both he and the Dietary Manager (staff #23) provide in-services and audits in the kitchen to make sure kitchen staff were compliant; and, in order to prevent the spread of infection and bad bacteria, food had to be stored, and served properly and that outdated food should be discarded and not be in the fridge. The IP said that the Dietary Manager was responsible for refrigerator audits. Review of the (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 035180
		If continuation sheet Page 1 of 14

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility policy titled Food Storage and Date Marking states Sufficient storage facilities are provided to keep food safe, wholesome, and appetizing. Food is stored in an area that is clean, dry and free from contaminants. Food is stored, prepared, and transported at appropriate temperatures and by methods designed to prevent contamination or cross contamination.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, resident and staff interviews and facility policy review, the facility failed to ensure the environment was free from pests. The deficient practice could result in the spread of germs. Findings included: On August 5, 2025 at 11:58 a.m. the resident was observed laying on his bed with a hat over his face. The resident was awake and stated that he put the hat on face because of the fly. A fly was observed flying around the resident's room and he stated that he has had flies in his room a couple of times. On August 6, 2025 at 11:09 a.m. multiple flies were observed on the wall by the refrigerator, on the tray line (serving area), and flying around in the kitchen, while observing the puree being prepared. The Dietary Manger (staff #23) stated that the administrator was aware of the issue and is trying to find a solution to the problem, but she was not aware of anything being done. She stated they will kill the flies, then wipe off the area where the fly was killed. During an interview conducted on August 6, 2025 at 12:06 p.m. with a resident (#24), a fly was observed on the resident's bedsheet and he was trying to shoo the fly away. On August 6, 2025 at 1:25 p.m., the resident's (#29) family stated that the flies were a problem and worse than normal today. He stated that he talked to the Administrator approximately two weeks ago about putting in air curtains on the outside doors which were used when he worked in a warehouse where food was stored. He stated that he was going to follow up with the Administrator about the flies. An interview was conducted on August 7, 2025 at 8:20 a.m. with the Administrator (Staff #34), who stated that the Maintenance Director was in charge of pest control, but his last day working for the facility was on Tuesday. He stated that the facility had a contract with a pest control company to spray the exterior of the building monthly and as needed. He stated that they get flies towards the end of the monsoon season and he was aware that this occurs during the season. He stated that there were fly traps at the edge of the property away from the building and they have told staff to limit exiting and entering the building through the courtyard to mitigate flies from entering the building. He has also reminded staff to keep food covered. He stated that the concern was reported to him on August 5, 2025. He stated that the pest control company does provide service for flies, but he has not contacted the company. He said that he was looking into ordering air curtains for the doors. During the interview, a small fly landed on the surveyor's hand. The administrator acknowledged that he was in charge of maintenance which included pest control at this time. The facility policy, Pest Control states that the facility shall maintain an effective pest control program.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and the facility policy and procedures, the facility failed to ensure that one resident (#56) was afforded privacy during a medical consultation. The deficient practice could result in residents' rights to privacy not being respected. Findings included: Resident (#56) was admitted to the facility on [DATE] with diagnoses that included heart failure, hyperlipidemia, and a hip fracture. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 12 indicating the resident was cognitively intact. A psych note completed on August 5, 2025 at 12:15 p.m. revealed an encounter was conducted and completed with the patient's/guardian's consent over telemedicine, including both audio and video components due to the client being located in a different location than the provider. Patient location: Address of record, Facility. The patient was sitting in wheelchair in her room. She reported feeling better than last visit, less shortness of breath, and has been happy lately. She stated she is sleeping and eating well and denied any concerns. The resident had a brief interview for mental status score (BIMS) of 12 dated July 21, 2025. On August 5, 2025 at 11:27 a.m. a behavior health technician (staff #10) was observed entering resident #24's room without knocking or asking if she could enter. Staff #106 began conducting a telemedicine with resident #24, while the surveyor was interviewing resident #24's roommate. The doctor was asking the resident questions about her health and staff #106 was repeating the questions loudly because the resident was hard of hearing. Staff #106 was loud enough for the roommate and surveyor to hear what was being discussed and the residents answers could also be heard. Doctor wanted to know if the resident was feeling okay because she was feeling well before. The surveyor exited the room and waited for the consultation to be completed, so the resident could complete the consultation in private and waited to interview staff #106. When attempting to interview staff #106 she was asked her name and she stated that it didn't matter because she doesn't work for the facility and left. On August 5, 2025 11:30 a.m., a therapy technician (staff #112) was observed entering resident #24's room without knocking or asking if she could enter. She asked if the resident was ready for therapy. An interview was conducted on August 7, 2025 9:28 a.m. with a certified nursing assistant (CNA/staff #31), who stated that she has received training on resident rights which includes the right to privacy. She stated that she needs to knock, greet the resident, identify herself, and explain what procedure she is going to provide for the resident. If there was a roommate, and she was going to discuss something, she would talk in low voice to ensure the resident's privacy. If she was going to provide care, she would shut the door and pull the curtain to maintain privacy. An interview was conducted on August 7, 2025 at 12:25 p.m. with the Director of Nursing (DON/staff #), who stated that all staff receive training on resident rights, which includes the right to privacy. Staff are trained to knock on the resident's bedroom door, introduce his or herself and wait for the resident to respond. She also stated that in order to maintain privacy, it is her expectation that staff that telemedicine be conducted in a private area. The facility policy, Resident Rights/Dignity: Resident Rights Guidelines for All Nursing Procedures states that for any procedure that involves direct resident care, follow these steps: knock and gain permission before entering the resident's room. Introduce yourself to the resident if he/she is unfamiliar with you, or if he/she may not recognize you due to memory loss. If visitors are present, ask them to wait outside unless the resident requests that they remain in the room.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on documentation, staff and resident interviews, and the facility policy and procedures, the facility failed to ensure that an allegation of exploitation for one resident (#24) was reported and investigated. The deficient practice could result in continued exploitation of residents. Findings include: Resident (#24) was admitted to the facility on [DATE] with diagnoses that included type II diabetes, acquired absence of unspecified leg below the knee, and chronic kidney disease. Review of the Personal Property Inventory list dated March 25, 2025 did not reveal that the resident had a cell phone. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 12 indicating the resident had a moderate cognitive impairment. Review of a grievance report dated July 28, 2025 revealed that the resident said that his phone had been missing since the weekend. The resident reported seeing another resident going into his room and his wallet and phone was then missing. The resident's room along with the facility was searched, but the phone was not found. The resident was to be reimbursed for the phone, but did not know the cost of the phone, but will let the Administrator know the cost of the phone. Review of the progress notes dated July 2025 did not reveal any documentation regarding the resident's complaint about his missing phone and seeing another resident in his room. Review of the Resident Relations Manager (Staff# 71's) documentation revealed that she attempted to contact the resident's family member on July 28, 2025 and there was no answer, and twice on August 6, 2025 and left a message requesting a call back. The documentation did not reveal the reason for the calls. During the initial interview conducted on August 5, 2025 at 12:04 p.m., the resident reported that his phone was missing from his room and the facility didn't do anything about it. He stated that there are some ladies in the facility that go around and take things from residents' rooms. An interview was conducted on August 6, 2025 at 7:27 a.m. with the Resident Relations Manager (Staff/ #71), who stated that she was responsible for the resident activities program and social services duties. Duties include documenting resident complaints on the grievance form and following up with the resident once the complaint has been investigated. She stated that a missing phone would be reported to the Administrator and residents are usually reimbursed for missing personal property. The resident reported the missing phone and he was going to ask his ex-wife what type of phone he had, so the facility could replace the phone. The phone was not on the inventory list, but she saw him with the phone and she had helped him make phone calls on the phone. During an interview conducted on August 6, 2025 7:57 a.m. with the Administrator (Staff #34), he stated that the facility will replace the phone by the end. During an interview conducted on August 6, 2025 at 12:06 p.m. with the Resident Relations Manager (Staff/ #71), she stated that she has received training on abuse which includes misappropriation of a resident's belongings and if the phone was taken, it is a form of misappropriation. She stated that if there is a possibility of abuse, it must be reported to the Administrator and he reports it to the state agency and completes the investigation. She is aware of residents wandering into other residents' rooms, but doesn't know their names. Staff and the surveyor went to speak with the resident and he stated that he would leave his phone on his tray when he went to therapy. He went to therapy and when he came back, the phone was missing. During an interview conducted on August 7, 2025 at 8:20 a.m. with the Administrator (Staff #34), he stated that he reported the allegation of the missing phone to the state agency yesterday, August 7, 2025, when it was identified as stolen. He stated that the resident had reported the phone missing; the facility searched for the phone and it was not found. He stated that it was possible that the phone was misappropriated, but highly unlikely that it was stolen. He stated that the resident went to one appointment and was transported in a vehicle owned by the facility to and from the appointment. The facility called the place where the resident had the appointment and searched the vehicle, but did not find the phone. He stated that the facility internally investigated and (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	determined that the phone was not stolen. He stated that they did not document any interviews with residents, but talked to a few located around the resident's room and did not document any interviews with staff. He stated that the resident had mentioned some Spanish speaking women (residents) that wander around. The facility policy, Resident Rights/Dignity: Abuse, Neglect, Exploitation and Misappropriation Prevention Program states that the facility must identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that medications were administered as prescribed for one resident (#24). The deficient practice could impact the health and wellbeing of the residents. Findings included: Resident (#24) was admitted to the facility on [DATE] with diagnoses that included type II diabetes, acquired absence of unspecified leg below the knee, and chronic kidney disease. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 12 indicating the resident had a moderate cognitive impairment. The order summary included: -March 25, 2025, Oxycodone-Acetaminophen oral tablet 5-325 mg give one tablet by mouth every four hours as needed for pain scale of 7-10.-April 6, 2025, Insulin Lispro (1 unit Dial) Subcutaneous Solution Pen-injector 100 unit/ml Inject as per sliding scale: if 0-179=0, Notify MD if BS 60 or below, follow hypoglycemic protocol. 180-200=3 units; 201-230=4 units; 231-260=5 units; 261-290=7 units; 291-320=9 units; 321-350=11 units; [PHONE NUMBER]=13 units. Notify MD if BS is 351 and over, document in NN. Follow hyperglycemic protocol, subcutaneously before meals and at bedtimes related to type II diabetes mellitus without complications. The care plan dated March 25, 2025 revealed the resident has a diagnosis for Diabetes Mellitus. Interventions included that the resident is dependent on insulin for management of diabetes. Monitor, document, and report to the physician as needed for serious symptoms (s/sx) of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing, acetone breath (smells fruity), stupor, and coma. The care plan dated [NAME] 25, 2025 included that the resident is on opiate medication. Interventions included to educate the resident on he potential risks, adverse outcomes, complications, and medication interactions associated with opioid use including death. An interview was conducted on August 6, 2025 at 10:44 a.m. with a registered nurse (RN/staff #50), who stated that an order for insulin should include: the name of the resident, amount, and slide scale parameters. She would check the resident's blood sugar level (BS) and then administer the amount of units based on the sliding scale. She stated giving insulin outside of the scale/range could cause the resident to be hypoglycemic or hyperglycemic. She stated that if the BS is too high, she would contact the physician for further instructions which may include monitoring the resident and even to administer more insulin; the physicians instructions should be documented in the progress notes. She would follow hyperglycemic protocol, which is to check the resident's BS every half hour to an hour to see if the insulin worked. When administering pain medication as needed (PRN), the order should have the dosage and the pain scale parameters and if the parameters are not followed, there is a risk of overmedicating the resident and the physician should be contacted for further instructions. She reviewed the MAR dated July 2025 and stated that the resident's BS was 356 on July 11, 2025 at 8:00 p.m., 13 units of insulin was administered, and the resident's BS was 371 on July 13, 2025 at 11:00 a.m., 13 units of insulin was administered. She stated that the physician should have been notified as per the order and the hypoglycemic protocol should have been followed. She reviewed the progress notes and stated that there was no documentation regarding the physician being notified and then she reviewed the vitals to see if the hypoglycemic protocol was followed and stated that there were no additional BS checks for the resident on July 11, or July 13, 2025. Then she reviewed the MAR dated July 2025 and stated that Oxycodone-Acetaminophen oral tablet 5-325 mg give one tablet by mouth every four hours as needed for pain scale of 7-10 was administered on July 6, 2025 at 12:00 p.m. for a pain level of 0 which was outside the pain parameters. She stated that administering pain medication outside of the parameters could cause an overdose. An interview was conducted on August 6, 2025 at 11:28 a.m. with the Director of Nursing (DON/staff #10), who stated that a physician's order is needed to administer insulin per a sliding scale and the purpose of administering insulin per a sliding scale is so the correct amount of insulin is administered based on the resident's blood sugar level (BS). She (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that if the order included instructions to contact the physician when the BS is above a certain level, it is her expectation that the nurse contact the physician and document the instructions given by the physician in the progress notes. She stated that if the physician is not notified and the resident is not being monitored, there is a risk of the resident becoming more hypoglycemic which could result in a coma. She stated that when the resident's BS is high, it is her expectation that the nurse continue to monitor the resident's BS level. She stated that when pain medications administered as needed (PRN), the nurse should follow the pain scale parameters on the order and if not followed, there is a risk of the resident overdosing. The facility policy, Medication Orders states that medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. It did not include that order must be followed when medications are administered.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and record review, the facility failed to provide an ongoing activity program that provided activities to meet the individual interests and needs to enhance the quality of life for one resident (#12). The deficient practice could result in resident isolation and decreased quality of life. Findings included: Resident #12 was admitted to the facility on [DATE]. The diagnosis included pleural effusion, not elsewhere classified, thoracic, difficulty in walking, not elsewhere classified aortic ectasia, chronic obstructive pulmonary disease, unspecified, difficulty in walking, not elsewhere classified, muscle weakness (generalized). The physician orders dated July 16, 2025 revealed that the resident may participate in overall activity plan and exercise program that do not interfere with treatment plan. The admissions activity's assessment dated [DATE] revealed that having books, newspapers, and magazines to read was not very important to the resident. Per the documentation, listening to music and going outside to get fresh air when the weather is good was somewhat important to the resident. The documentation also included that being around animals such as pets, doing favorite activities and participating in religious services or practices were very important to the resident. Activities of interest included arts and crafts, gardening/arranging, and pets. Therapeutic interventions included the need for reading glasses. Holistic interventions for pain, anxiety and behaviors were music. The care plan dated July 25, 2025 included that the resident had previous recreational interests and patterns meeting with friends, time alone, watching TV and potential for altered activity pattern; and, was dependent on staff for activities, cognitive stimulation, social interaction. Interventions included to provide leisure supplies for self-directed pursuits, introduce to other residents with similar interests, disabilities, and/or limitation and offer a variety of activity types and locations; assist with arranging community activities, arrange transportation, assistance with activities of daily living (ADLs) as required during the activity and assistance/escort to activity functions. The Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status with a score of 12, indicating moderate cognitive impairment. The assessment also included that resident was usually understood with some difficulty communicating some words or finishing thoughts, but was able if prompted or given time; and, required partial to moderate assistance with wheelchair use. Review of the Activities Task tab for the following areas of interest during the 30 day-look back period: Arts and crafts Group programs Music Special events/parties/socials Spiritual services Room visit Cultural activities Bingo However, the documentation does not indicate whether the resident was offered or participated in any activities, except on August 5, 2025, when they were marked as yes for special events and refused for a room visit. Review of the activity participation progress notes revealed no documentation for resident #12 since admission date of July 16, 2025. An interview was conducted with resident #12 conducted on August 5, 2025 at 11:13 a.m. revealed an activity calendar hanging on the resident's closet door. Resident #12 stated that she did not know what the activity calendar was and did not know anything regarding activities, but would like to attend. Resident #12 stated that no one has come to invite or tell her about the daily activities. In an interview conducted with Resident #12 on August 6, 2025, at 1:25 p.m., the resident stated that staff had not invited her to activities and that she only attended one because she happened to be near the activity room when it started. She said that someone had left her a puzzle book, but she was unable to use it because she did not have her reading glasses. She also said there was a flyer on her cupboard, which she later learned was an activity schedule, but she could not read it without her glasses. Resident #12 further stated that she would appreciate help getting to activities, as she often does not know what was happening; and, she was from another state, does not know anyone locally, and would like to meet more people and participate in more activities if staff would invite her. An interview was conducted on August 6, 2025, at 11:34 a.m. with Certified Nursing Assistant (CNA/Staff #1) who stated that she helps residents participate in (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	activities of their choice by informing them about scheduled events and encouraging them to attend. She said that if a resident has therapy, medications, or ADL (activities of daily living) needs, she ensures their schedule was coordinated so they can still participate in activities. The CNA also said that if she notices a resident refusing activities or showing a change in participation, she reports it to the nurse. She added that activity staff were present daily to meet residents' activity needs. An interview with the Activities Manager (Staff #71) was conducted on August 6, 2025, at 1:34 p.m. The Activities Manager stated that the activity program was run by herself and three activity assistants. She said that the facility holds care plan meetings to identify each resident's needs, interests, cultural background, and preferences, including family input. She said the activities department offers both group and individualized activities, with ideas for new activities gathered through resident council meetings and direct conversations with residents. The Activities Manager stated that resident activity participation-including level of participation, whether activities were offered, and any refusals-was documented in the electronic record. She said that to ensure residents are encouraged or invited to activities, staff were expected to personally visit and invite each resident to activities suited to their interests. During the interview, a review of Resident #12's clinical record was conducted. The Activities Manager said that there was no documentation showing activities were offered or refused for each of the resident's identified areas of interest. She further stated that August 6, 2025, was the first day staff had offered an activity to Resident #12. During an interview with the Administrator (Staff #34) on August 6, 2025, at 2:16 p.m., the Administrator stated that his expectations for the activity program and staff were to ensure that residents are asked about the activities they want to participate in, their likes, and cultural preferences. He said that staff should be inviting residents to activities, posting schedules so residents are aware of what is being offered, and most importantly, personally inviting them-even if they refuse. The Administrator stated that failing to do so could result in resident isolation. Review of the facility policy titled Personal Care: Activity Evaluation revealed that in order to promote the physical, mental and psychosocial well-being of residents, an activity evaluation is conducted and maintained for each resident at least quarterly and with any change of condition that could affect his/her participation in planned activities. An activity evaluation is conducted as part of the comprehensive assessment to help develop an activities plan that reflects the choices and interests of the resident. The activity evaluation is used to develop an individual activities care plan (separate from or as part of the comprehensive care plan) that will allow the resident to participate in activities of his/her choice and interest. Each resident's activities care plan relates to his/her comprehensive assessment and reflects his/her individual needs		

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NAME OF PROVIDER OR SUPPLIER Haven of Douglas		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 North San Antonio Avenue Douglas, AZ 85607	
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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 interviews, review of clinical record, and review of facility policy, the facility failed to ensure a physician order was followed for one resident (#1) regarding a laboratory order. The deficient practice could lead to diagnostic testing not being completed and a missed diagnosis. Findings include: Resident #1 was re-admitted to the facility December 30, 2023, with diagnoses that included pneumonitis due to inhalation of food, acute respiratory failure, type 2 diabetes mellitus with diabetic neuropathy, repeated falls, adult failure to thrive, personal history of sudden cardiac arrest, anxiety disorder, major depressive disorder, cannabis use in remission, contracture of muscle, paranoid schizophrenia, and bipolar disorder. A quarterly minimum data set (MDS) assessment dated [DATE], revealed the resident had a brief interview for mental status (BIMS) score of 15, indicating intact cognition. Section E revealed the resident had no behavioral symptoms exhibited. A physician order dated April 9, 2025, indicated for a urinalysis reflex test and toxicology screen, and that the toxicology screen could be completed in-house (at the facility). A Health Status Note dated April 9, 2025, revealed the nurse noted the resident was talking slowly, and had pale-looking skin. Suddenly, the resident started laughing and acting out of the normal. The nurse noted that he was not behaving as usual. The nurse notified the physician, and the physician ordered a urinalysis with a toxicology screen. A review of the Medication and Treatment Administration Record (MAR/TAR) for April 2025 revealed the order for the urinalysis reflex test and toxicology screen was left blank, with no evidence that it was completed. Review of the clinical record revealed no evidence that the urinalysis reflex test and toxicology screen were completed and no evidence of any results and no evidence of any communication regarding the order. An interview was conducted with the Medical Records Manager (Staff #47) on August 6, 2025, at 8:49 a.m. Staff #47 stated that the facility utilizes a mobile laboratory company for laboratory orders and that the results are automatically uploaded in the electronic medical record. Staff #47 reviewed the clinical record for Resident #1 and stated that she could not locate any urinalysis results for April 2025. An interview was conducted with a Registered Nurse (RN / Staff #63) on August 6, 2025, at 9:02 a.m. Staff #63 stated that if there is an order for a urinalysis, then the nurse would schedule the laboratory order, and the mobile laboratory company completes the order and automatically uploads the results in the resident's electronic medical record. Staff #63 reviewed Resident #1's clinical record and stated that he could not locate the resident's urinalysis results from April 2025. An interview was conducted with the Director of Nursing (DON / Staff #10) on August 6, 2025, at 9:18 a.m. The DON reviewed the MAR/TAR for April 2025 and stated that the urinalysis and toxicology screen order was not marked as completed. The DON stated that she would reach out to the mobile laboratory company to see if there were any results from that date. An additional interview was conducted with the DON on August 6, 2025, at 10:28 a.m. The DON stated that she talked to the nurse who completed the toxicology screen in-house for Resident #1, but that the nurse did not document its completion or the results. Additionally, the DON stated that the nurse did not read the whole order and that the urinalysis was not collected, so there was no documentation of it. A follow-up interview was conducted with the DON on August 7, 2025, at 11:31 a.m. The DON stated that her expectation is that staff should follow physician orders. The DON stated that if a lab or test is ordered by a physician and not completed by staff, then the risk to a resident could be that an infection could be missed or abnormal lab results not caught by the clinical team. Regarding the missed urinalysis laboratory order for Resident #1, the DON stated that it would not meet her expectation, and that staff should have asked the physician for a repeat order for collecting the urinalysis and that the results of the toxicology screen should have been documented in the medical record to help subsequent clinical team members track to make sure things are done. Review of the facility policy titled Medication Orders, revised November 2014, revealed that each resident must be under the care of a Licensed Physician authorized to practice medicine in this state, and that (continued on next page)		

Department of Health & Human Services
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a current list of orders must be maintained in the clinical record of each resident. Review of the facility policy titled Charting and Documentation, revised April 2008, revealed that all services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. Documentation of procedures and treatments shall include care-specific details and shall include at a minimum the date and time the procedure/treatment was provided, the assessment data and/or any unusual findings obtained during the procedure/treatment, and the name and title of the individual(s) who provided the care.		

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, clinical record review, and review of facility policy and procedure, the facility failed to ensure speech therapy services were provided for one resident (#8) when indicated. The deficient practice could lead to residents not receiving rehabilitative services when indicated to assist in reaching their highest practicable level of function. Findings include: Resident #8 was originally admitted to the facility August 2, 2016, and re-admitted to the facility April 16, 2023, with diagnoses that included adjustment disorder with mixed anxiety and depressed mood, aphasia following cerebral infarction, functional dyspepsia, dysphagia, contracture of muscle in multiple sites, epilepsy, and cerebral infarction. A care plan dated December 17, 2019, revealed that Resident #8 has a communication problem due to stroke and unable to form words, and that the resident uses sounds, gestures, and inflection of tone to communicate. Interventions included for staff to anticipate and meet the resident's needs, and to monitor, document, and report to the physician changes in Resident #8's ability to communicate and potential for improvement. A quarterly minimum data set (MDS) assessment dated [DATE], revealed Resident #8 had a brief interview for mental status (BIMS) assessment that was not attempted, as the resident was rarely or never understood. A Quarterly Nursing Summary Note dated November 27, 2023, revealed Resident #8 was rarely/never understood when expressing ideas and wants, and that the resident had aphasia and used sounds or jesters for communicating. A Therapy Services Screen dated January 16, 2024, and signed by a Speech Language Pathologist (SLP / Staff #91), revealed a speech therapy evaluation was recommended due to Resident #8's poor speech intelligibility post cerebrovascular accident (CVA / stroke), and that the resident's family had requested speech therapy services. The screen revealed that speech therapy indicators for Resident #8 included impaired ability to verbalize simple and complex ideas, and impaired intelligibility. Additionally, the screen revealed that the resident was observed, and a speech therapy evaluation was recommended. Despite the recommendation for a speech therapy evaluation, the clinical record was reviewed and revealed no evidence of communication of the recommendation to the physician or the clinical team, and no evidence of any speech therapy orders at that time, and no evidence that speech therapy services were provided then. Another Quarterly Nursing Summary note dated March 7, 2024, revealed the resident was oriented x 3, and unable to form sentences and words. Additionally, the resident was rarely/never understood when expressing ideas and wants. An additional quarterly MDS assessment dated [DATE], revealed that a BIMS assessment was not attempted, as the resident was rarely or never understood. An observation was conducted on August 6, 2025, at 11:12 a.m. of Resident #8 in his room. Resident #8 was sitting in his wheelchair. An interview was attempted at that time, however, the resident was unable to form phrases or sentences to communicate. An interview was conducted on August 6, 2025, at 12:00 p.m. with the Director of Rehabilitation (DOR / Staff #86), who stated that the therapy department conducts therapy screens to determine if a resident may need therapy services, or the nursing staff will communicate with the therapy department to alert therapy staff if a resident may need therapy services. The DOR stated that then, an authorization (auth) request is placed with the resident's insurance to determine the resident's insurance coverage for therapy visits. The DOR reviewed the clinical record for Resident #8 and stated that Resident #8 had a therapy screen completed on January 16, 2024, and that it was recommended that he be evaluated by speech therapy. The DOR stated that no speech therapy evaluation was completed in 2024. The DOR also stated that the record revealed no therapy screens were conducted for the year 2025, and that the resident had no therapy evaluations completed in 2025. An interview was conducted with the Director of Nursing (DON / Staff #10) on August 6, 2025, at 12:22 p.m. The DON stated that for long term care residents, that if staff notice a change in a resident, or if the resident or their family requests therapy services, then the resident would be referred to the therapy department and screening is completed. The DON stated that then the facility staff (continued on next page)		

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	determines if the resident can be approved by insurance for therapy services.A formal request was submitted to the facility on August 6, 2025, at 12:40 p.m. for any insurance auth requests for Resident #8 for 2024-2025, and additionally, for any speech therapy evaluations and treatment notes for 2024-2025.The facility provided a signed statement dated August 6, 2025, that there were no insurance auth requests and no speech therapy notes completed for Resident #8 for the requested timeframe.An interview was conducted on August 6, 2025, at 2:07 p.m. with a Licensed Practical Nurse and Care Coordinator (LPN / Staff #17), who stated that there were no insurance auth requests submitted in January 2024 for Resident #8, and that there were no physician orders for speech therapy for that timeframe.An interview was conducted with the Business Office Manager (Staff #35) on August 7, 2025, at 8:26 a.m. Staff #35 stated that if a resident is recommended for therapy and requires insurance authorization for visit coverage, then the therapy department staff will bring a form to Staff #35, and that Staff #35 verifies the insurance plan for the resident. Then, Staff #17 is in charge of requesting insurance authorization from the insurance.An interview was conducted with the Director of Nursing (DON) on August 7, 2025, at 11:31 a.m. The DON stated that Resident #8 had a history of a stroke and that he had speech impairments. The DON stated that Resident #8 is able to state yes and no, and is able to make noises, and point and make gestures, however Resident #8 could not form phrases or sentences to communicate. The DON stated that her expectation if a resident or family member requests therapy services, and a licensed clinician screens that resident and identifies the need for further evaluation from a speech therapist, that the staff should follow physician orders and provide the recommended rehab services. The DON stated that in the case of Resident#8, that the previous speech therapist (Staff #91) had screened the resident in January 2024 and had failed to communicate the recommendation for speech therapy to the physician or the rest of the clinical team, and that is why there was no physician order for speech therapy and no insurance auth request or subsequent therapy visits. The DON stated that if the clinical team had received the communication regarding the recommendation for speech therapy for Resident #8, then the staff would have obtained physician orders and requested auth from the insurance. The DON stated that this was the first time the clinical team had seen the speech therapy screen note. The DON stated that fortunately, Resident #8 had not shown a functional decline, but additionally, that the DON would expect a trial of therapy, when recommended, to determine if that resident could achieve a better level of function.Review of the facility policy titled Rehabilitative / Restorative Care: Functional Impairment - Clinical Protocol, effective January 1, 202, revealed that upon admission to the facility, whenever a significant change of condition occurs, and periodically during a resident's stay, the physician and staff will assess the resident's function along with their physical condition. The staff and physician will identify individuals with potential for significant improvement in function or significant decline in function, including the ability to perform activities of daily living (ADLs). The staff and physician will collaborate to identify a rehabilitative or restorative care plan to help improve function and quality of life and meet a resident's goals and needs and attain other desired outcomes such as discharge to the community.Review of the facility policy titled Rehabilitative / Restorative Care: Speech Therapy, effective January 1, 2024, revealed that the purpose of the procedure is to identify, assess and treat speech and language problems, including swallowing disorders. Preparation included to review the resident's care plan to assess for any special needs of the resident. Speech therapists treat stroke survivors and other brain injury survivors who experience impaired ability to swallow or have difficulty expressing thought or understanding language. These residents may experience aphasia. Expressive aphasia is a problem with what to say. Receptive aphasia is a problem with understanding what has been said. The speech therapist works with other rehabilitation and medical professionals and families to provide a comprehensive evaluation and treatment plan for residents with any of the problems in speech listed above.Review of the facility policy titled Rehabilitative / Restorative Care: Scheduling Therapy Services, effective January 1, 2024, revealed the therapist shall interview the resident and consult with the attending physician as to the type of treatment to be administered.		