STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035233	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Globe	1100 Monroe Street Globe, AZ 85501

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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 clinical record review, interviews, documentation and policy, the facility failed to report the results of abuse allegation investigations to the state survey agency within 5 working days of the incident for 2 of 18 sampled residents (#12, #92) in accordance to state law. The deficient practice could result in facilities not submitting investigation reports to the State Survey agency within 5 working days.Findings include:Regarding Resident #92-Resident #92 was admitted on [DATE] with diagnosis that included Type 2 Diabetes Mellitus, dementia, and blindness of one eye. A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status of 99, which indicated that the assessment could not be completed. A Staff Assessment for Mental Status assessment revealed Short-Term and Long-Term memory problems, and severely impaired daily decision making. Review of clinical records dated December 21, 2022 through December 29, 2022 revealed that the resident had to be redirected back to her room several times, and wandered multiple times throughout residents' rooms and on various hallways, and wandering requires supervision.An Alert Charting progress note dated April 30, 2023, revealed that it was reported to the nurse by the CNA and [NAME] that a physical altercation took place. The note indicated that the CNA, reported that a scream was heard, and the CNA went to investigate and found Resident #92 in her wheelchair just outside the door of Resident #12's room. The CNA reported that Resident #12 stated that she pulled Resident #92's hair because Resident #92 keeps coming in Resident #12's room. The note included that the two residents were then separated and that neither of the resident's had any visible markings or signs of injury. The report further revealed that the provider, Director of Nursing, case manager and the residents' families were notified. The report included that a police report was initiated, statements were taken, and both residents would be monitored and kept at a safe distance. -Regarding Resident #12 (alleged perpetrator) Resident #12 was admitted on [DATE] with diagnoses of Dementia, major depressive disorder, schizophrenia, anxiety disorder, hallucinations and blindness. An admission MDS dated [DATE], revealed a BIMS score of 14, which indicted intact cognition. The assessment also revealed no evidence of behavioral symptoms related to physical or verbal behaviors directed toward others. An Alert Charting progress note dated April 30, 2023, revealed that a CNA, reported that a scream was heard, and the CNA went to investigate, and found Resident #92 in her wheelchair just outside the door of Resident #12's room. The CNA reported that Resident #12 stated that she pulled Resident #92's hair because Resident #92 kept coming into Resident #12's room. The note included that the two residents were then separated and that neither of the resident's had any visible markings or signs of injury. The report further revealed that the provider, Director of Nursing, case manager and the residents' families were notified. The report included that a police report was initiated, statements were taken, and both residents would be monitored and kept at a safe distance. A Facility Reported Incident (FRI) was received by the State Agency on April 30, 2023. The report revealed that a CNA heard Resident #92 holler out, and found that Resident #12 had pulled Resident #92's hair.However, the facility was unable to provide evidence that the investigation results were investigated and submitted to the State Agency within 5 working days of the incident, following the (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	facility's policy. The State Agency Complaint Tracking System revealed no evidence that the facility investigation was submitted within 5 working days of the incident as required. On June 8, 2026 at 12:10 p.m. an interview was conducted with the Administrator (staff #300) who stated that the facility did not keep internal incident reports or risk management reports after 12 months following the completion date. It was reported that the facility policy was to maintain investigation records for 12 months following completion of the 5-day report. An interview was conducted on June 9, 2026 at 1:36 p.m. with the Director of Nursing (DON/Staff #83), who stated that the facility policy included to submit the completed facility investigation 5-day report to the state agency and Adult Protective Services. The DON further stated that the facility keeps the completed 5-day reports for a year. The DON also stated that she would not know if an investigation/5-day report had been completed and submitted to the state agency per the facility policy, because the facility keeps the investigation reports for 12 months. The DON stated that if the investigation 5-day report had been completed per their policy, the investigation would have been submitted to the state agency. However, review of the State Agency Complaint Tracking System revealed no evidence that the facility investigation had been submitted to the state agency. A facility policy titled, Resident Rights/Dignity: Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revealed that the facility must identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation. The policy also revealed that the facility must investigate and report any allegations within timeframes required by federal requirements. The policy relayed that the facility-wide program commitment included to develop and implement policies and protocols to prevent and identify abuse. A facility policy titled, Resident Rights/Dignity: Abuse investigation and Reporting revealed that all reports of resident abuse shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. The Administrator or his/her designee will provide the appropriate agencies with a written report of the findings of the investigation within five-working days of the occurrence of the incident. A facility policy titled, Abuse Policy, revealed that if abuse is witnessed or suspected, reporting and investigation will take place, and when the investigation is complete the Executive Director (ED) will submit a summary to Adult Protective Services, Ombudsman, State Survey Agency, and law enforcement.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to ensure that in response to allegations of abuse, that all alleged violations are thoroughly investigated, for 2 of 18 sampled residents (#12 and #92). The deficient practice could result in allegations of abuse not being thoroughly investigated. Findings include: -Regarding Resident #92 (alleged victim) and Resident #12 (alleged perpetrator): -Resident #92 was admitted on [DATE] with diagnosis that included Type 2 Diabetes Mellitus, dementia, and blindness of one eye. A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status of 99, which indicated that the assessment could not be completed. A Staff Assessment for Mental Status assessment revealed Short-Term and Long-Term memory problems, and severely impaired daily decision making. Review of clinical records dated December 21, 2022 through December 29, 2022 revealed that the resident had to be redirected back to her room several times, and wandered multiple times throughout residents' rooms and on various hallways, and wandering requires supervision.A care plan initiated on December 28, 2022, revealed a focus related to a behavior problem related to wandering/exit-seeking, verbal behaviors, with interventions that included if issues arise, remove from situation, explain/reinforce why the behavior is inappropriate and/or unacceptable, intervene as necessary to protect the rights and safety of others. A quarterly Minimum Data Set (MDS) assessment dated [DATE], A Staff Assessment for Mental Status assessment revealed Short-Term and Long-Term memory problems, and severely impaired daily decision making. The MDS also revealed the presence of verbal behavior toward others, and that wandering occurred 1-3 days during the assessment period An Alert Charting progress note dated April 30, 2023, revealed that it was reported to the nurse by the CNA and [NAME] that a physical altercation took place. The note indicated that the CNA, reported that a scream was heard, and the CNA went to investigate and found Resident #92 in her wheelchair just outside the door of Resident #12's room. The CNA reported that Resident #12 stated that she pulled Resident #92's hair because Resident #92 she keeps coming in Resident #12's room. The note included that the two residents were then separated and that neither of the resident's had any visible markings or signs of injury. The report further revealed that the provider, Director of Nursing, case manager and the residents' families were notified. The report included that a police report was initiated, statements were taken, and both residents would be monitored and kept at a safe distance. -Resident #12 was admitted on [DATE] with diagnoses of Dementia, major depressive disorder, schizophrenia, anxiety disorder, hallucinations and blindness. An admission MDS dated [DATE], revealed a BIMS score of 14, which indicted intact cognition. The assessment also revealed no evidence of behavioral symptoms related to physical or verbal behaviors directed toward others. A care planned focus initiated April 1, 2023, revealed a behavior problem related to physical and verbal aggression towards other residents, resident is not to be within arm's reach of other residents at any time, resistive to care, verbal behavior and wandering. An Alert Charting progress note dated April 30, 2023, revealed that a CNA, reported that a scream was heard, and the CNA went to investigate, and found Resident #92 in her wheelchair just outside the door of Resident #12's room. The CNA reported that Resident #12 stated that she pulled Resident #92's hair because Resident #92 kept coming into Resident #12's room. The note included that the two residents were then separated and that neither of the resident's had any visible markings or signs of injury. The report further revealed that the provider, Director of Nursing, case manager and the residents' families were notified. The report included that a police report was initiated, statements were taken, and both residents would be monitored and kept at a safe distance. A Facility Reported Incident (FRI) was received by the State Agency on April 30, 2023 which revealed that a CNA heard Resident #92 holler out, and found that Resident #12 had pulled Resident #92's hair.However, the facility was unable to provide evidence that the incident had been thoroughly investigated, or that the completed investigation results were (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	submitted to the State Agency within 5 working days of the incident. The State Agency Complaint Tracking System revealed no evidence that the facility investigation was submitted within 5 working days of the incident as required. On June 8, 2026 at 12:10 p.m. an interview was conducted with the Administrator (staff #300) who stated that the facility did not keep internal incident reports or risk management reports after 12 months following the completion date. It was reported that the facility policy was to maintain investigation records for 12 months following completion of the 5-day report. An interview was conducted on June 9, 2026 at 1:36 p.m. with the Director of Nursing (DON/Staff #83), who stated that the completed facility investigation 5-day report would be sent to the state agency and Adult Protective Services. The DON further stated that the facility keeps the completed 5-day reports for a year. The DON stated that the only way a person would know that the incident occurred or had been investigated would be through progress notes in the residents' clinical records. The DON also stated that she would not be able to provide proof of a thorough investigation because their investigation reports are not kept over 1 year. The DON stated that if the investigation 5-day report had been completed it would have been submitted to the state agency. The DON further stated that if the State Agency did not have the investigation 5-day report, then she would not be able to prove that the investigation was conducted. However, review of the State Agency Complaint Tracking System revealed no evidence that the facility investigation had been submitted to the state agency. A facility policy titled, Resident Rights/Dignity: Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revealed that the facility must identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation. The policy also revealed that the facility must investigate and report any allegations within timeframes required by federal requirements. The policy relayed that the facility-wide program commitment included to develop and implement policies and protocols to prevent and identify abuse. A facility policy titled, Resident Rights/Dignity: Abuse investigation and Reporting revealed that all reports of resident abuse shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. The Administrator or his/her designee will provide the appropriate agencies with a written report of the findings of the investigation within five-working days of the occurrence of the incident. A facility policy titled, Abuse Policy, revealed that if abuse is witnessed or suspected, reporting and investigation will take place, and when the investigation is complete the Executive Director (ED) will submit a summary to Adult Protective Services, Ombudsman, State Survey Agency, and law enforcement.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility assessment, facility documentation, interviews, and policy review, the facility failed to ensure there was sufficient staff to meet the needs of the residents. The deficient practice could result in residents not receiving the appropriate care to maintain safety, and the highest practicable physical, mental, and psychological well-being as determined by resident assessments and individual plans of care.Findings include:The PBJ (Payroll-Based Journal) Staffing Data Report revealed that the facility consistently triggered for excessively low weekend staffing for all four quarters in 2025, and the first quarter of 2026. The facility assessment reviewed on June 9,2026, revealed the facility was licensed to provide care for 104 residents, had an average daily census of 78-85, and had an average number of 3-6 weekday admissions and 1-2 weekend admissions, and 2-5 weekday discharges and 0-3 weekend discharges. Staffing plan included the following:-full time Director of Nursing (DON)-full time Assistant Director of Nursing (ADON)-3 full time Registered Nurses (RN)/Licensed Practical Nurse (LPN) on AM shift (6:00 a.m. to 6:00 p.m.)-1 Certified Nursing Aide (CNA) for 10-13 residents on AM shift (6:00 a.m. to 6:00 p.m.)-2 full time RNs/LPNs on PM shift (6:00 p.m. to 6:00 a.m.)-1 CNA for 13-16 residents on PM shift (6:00 p.m. to 6:00 a.m.) The daily staffing assignment for May 9, 2026, revealed the following:-Census of 74:2 RN/LPNs were scheduled for the AM shift, which resulted in 37 residents, per nurse.4 CNAs were scheduled for the PM shift, which resulted in 18 Residents, per CNA.1 Certified Medication Aide (CMA) was scheduled for the AM and PM shifts.No [NAME], (staff who are responsible for answering to call bells, refill water pitchers, restock briefs and gloves, and empty the dirty laundry bins), was scheduled for either AM or PM shift. The daily staffing assignment for May 10, 2026, revealed the following:-Census of 75:2 RN/LPNs were scheduled for the AM shift, which resulted in 37 residents, per nurse.4 CNAs were scheduled for the AM and PM shifts, which resulted in 18 to 19 residents, per CNA.1 CMA was scheduled for the AM and PM shifts.1 [NAME] was scheduled for the AM shift. The daily staffing assignment for May 16, 2026, revealed the following:-Census of 77:2 RN/LPNs were scheduled for the AM shift, which resulted in 38 residents, per nurse.5 CNAs were scheduled for the AM shift, which resulted in 15 residents, per CNA.1 CMA was scheduled for the AM and PM shifts.1 [NAME] was scheduled for the PM shift. The daily staffing assignment for May 17, 2026, revealed the following:-Census of 77:2 RN/LPNs were scheduled for the AM shift, which resulted in 38 residents, per nurse.4 CNAs were scheduled for the AM and PM shifts, which resulted in 19 residents, per CNA.1 CMA was scheduled for the AM and PM shifts.2 Valets were scheduled for the AM shift. The daily staffing assignment for May 23, 2026, revealed the following:-Census of 78:2 RN/LPNs were scheduled for the AM shift, which resulted in 39 residents, per nurse.5 CNAs were scheduled for the AM shift, which resulted in 15 residents, per CNA.1 CMA was scheduled for the AM and PM shifts.1 [NAME] was scheduled for the AM shift. The daily staffing assignment for May 24, 2026, revealed the following:-Census of 77:2 RN/LPNs were scheduled for the AM shift, which resulted in 38 residents, per nurse.5 CNAs were scheduled for the AM shift, which resulted in 15 residents, per CNA.1 CMA was scheduled for the AM and PM shifts.1 [NAME] was scheduled for the AM shift. The daily staffing assignment for May 30, 2026, revealed the following:-Census of 72:2 RN/LPNs were scheduled for the AM shift, which resulted in 36 residents, per nurse.4 CNAs were scheduled for the PM shift, which resulted in 18 residents, per CNA.1 CMA was scheduled for the AM shift.1 [NAME] was scheduled for the PM shift. The daily staffing assignment for May 31, 2026, revealed the following:-Census of 71:2 RN/LPNs were scheduled for the AM shift, which resulted in 35 residents, per nurse.4 CNAs were scheduled for the AM shift, which resulted in 18 residents, per CNA.1 CMA was scheduled for the AM and PM shift.1 [NAME] was scheduled for the AM shift. The daily staffing assignment for June 5, 2026, revealed the following:-Census of 74:4 RN/LPNs were scheduled for the AM shift. The ADON and the DON were (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	also scheduled.4 CNAs were scheduled for the PM shift, which resulted in 18 to 19 residents, per CNA.1 CMA was scheduled for the PM shift.1 [NAME] was scheduled for the AM and PM shift. The daily staffing assignment for June 6, 2026, revealed the following:-Census of 73:3 RN/LPNs were scheduled for the AM shift.5 CNAs were scheduled for the AM shift, which resulted in 14 residents, per CNA.1 CMA was scheduled for the AM and PM shifts.1 [NAME] was scheduled for the PM shift. The daily staffing assignment for June 7, 2026, revealed the following:-Census of 71:2 RN/LPNs were scheduled for the AM shift, which resulted in 35 residents, per nurse.5 CNAs were scheduled for the AM shift, which resulted in 14 residents, per CNA.1 CMA was scheduled for the AM and PM shifts.1 [NAME] was scheduled for the AM shift.On December 15, 2025, the State Agency (SA) received a complaint that stated the facility was so short staffed that CNAs had 4 separate hallways of Residents to care for and Hoyer lifts were used by only 1 staff member, when 2 staff are required.An interview was conducted on June 9, 2026, at 9:39 AM, with the RN, staff #65. The RN stated staffing was low for nurses and CNAs. The RN stated it was typical to have a caseload of 35 plus Residents during a shift. The RN stated some of the CNAs have been trained as a CMA so they could aid the nurses in medication pass. The RN stated there are many tasks that cannot be completed during the shift; for example, a full set of vitals are not always completed, however, if a Resident is on a blood pressure medication, before the RN administered the medication, she would get a blood pressure reading but not have time to complete a full set of vitals. The RN stated getting weights on Residents were missed often due to not having enough time to complete the task. The RN stated on night shift, it was typical to run out of protein ice cream and calcium drinks due to the staff not having access to the supply room. The RN explained that night shift was not always stocked with supplies because day shift would not have enough staff to stock supplies for night shift. The RN stated the CNAs would not take lunch breaks due to not having enough time, however, she would take a lunch because she needed it. The RN stated she had stayed past her shift if there was a new admission or if a Resident sustained a fall.An interview was conducted on June 9, 2026, at 9:58 AM, with LPN, staff #85. The LPN stated there has been a struggle with staffing nurses and CNAs. She stated some CNAs had been trained for CMA to aid the nurses with medication pass. The LPN stated there were times the facility would ask sister facilities to assist with staffing. The LPN stated most times she does not take a break or a lunch break and Administration would ask her why. The LPN stated her response was I don't have time. The LPN stated she had stayed past her shifts to complete tasks she had been too busy to finish during her shift. An interview was conducted on June 9, 2026, at 10:11 AM, with Licensed Nurse Aide (LNA). The LNA stated her tasks were completed by the end of her shift, however there were days when a curveball would be thrown and change things. The LNA stated the protocol for a staff call-off was to notify the Staffing Coordinator/CNA, staff #66, who would contact other staff members. The LNA stated if other staff were not able to work the shift, then staff #66 would cover the shift. She stated she is scheduled for 4-12-hour days a week but typically works 5-12-hour days.An interview was conducted on June 9, 2026, at 10:34 AM, with Staffing Coordinator/CNA, staff #66. She stated the typical staffing plan for weekdays and weekends were as follows:-1 to 2 RNs for AM and PM shifts-1 to 2 LPNs for AM and PM shifts-5 CNAs for the PM shift-6 CNAs for the AM shift-1 [NAME] for the AM and PM shiftsStaff #66 stated staffing is done in my head. Staff #66 stated she had not used a computer program to determine staffing and did not know what the facility assessment was. She stated she thinks staffing is good. She stated if there were call-offs she would begin texting or calling other staff to see if they were able to pick up a shift, if she cannot find anyone she will pick up the shift.An interview was conducted on June 9, 2026, at 10:56 AM with DON, staff #83. The DON stated staffing was adequate. She stated the staff schedule is completed by using the facility assessment and the current census. Review of the staff schedules for weekends revealed the staff numbers dropped compared to during the week, however, the DON stated staffing is adequate due to the Valets and CMAs.An interview was conducted on June 9, 2026, at 1:34 PM, with the Administrator. She stated that staffing was adequate, however, call offs were a (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	problem. She stated the goal was to have 4-5 CNAs on night shift and 5-6 on day shift, and 3 nurses per shift, however, that goal was not always achieved so the CMAs were implemented. She stated staff #66 was good at reaching out to other staff members to pick up shifts, and the group messages also went to the department heads. If needed, department heads would come in and answer call bells. The Administrator stated incentives are offered to staff for working extra shifts. She stated the CNAs that were interested in becoming a CMA were cross-trained. Review of the staff schedule, daily staff postings, and the facility assessment for weekends, the Administrator stated she clearly saw they were short staffed on the weekends and the schedule did not match the facility assessment. She stated the CNAs who had a caseload of 19 Residents each was too much. Review of the facility's policy on Administrative Policies: Staffing, Sufficient and Competent Nursing dated January 1, 2024 stated Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Licensed nurses are required to supervise nurse aids/nursing assistants and are scheduled in such a way that permits adequate time to do so.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and policy review, the facility failed to ensure that drugs and biologicals were stored, secure, and inaccessible to unauthorized staff and residents in accordance with facility policy, state, and federal laws for four of eighteen sampled residents (#5, #22, #69, #89). The universe was seventy-one. The deficient practice could lead to medications being incorrectly administered or accidentally ingested by a resident. Findings Include: -Regarding Resident #5 Resident #5 was admitted on [DATE] with diagnosis including bipolar disorder, current episode-depressed, dementia-unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, psychosis not due to a substance or known psychological condition, schizoaffective disorder, essential hypertension, edema, dermatitis, cellulitis and pruritis. A review of the annual MDS (minimum data set) dated March 23, 2026 revealed a BIMS (brief interview of mental status) score of 99, indicating the interview could not be completed. A review of the physician orders revealed an order dated July 26, 2024 for Nystatin powder 100,000 unit/gm (gram) to apply topically every shift for fungal infection related to candidiasis-unspecified. However, there was no evidence of an order for self-administration of medications. Review of the care plan revealed a focus area including an alteration in neurological status due to dementia which was initiated on June 7, 2022 which noted interventions including to administer medications as ordered and monitor/ document for side effects and effectiveness. A further focus area was documented, noting that the resident has impaired cognitive function/ dementia or impaired thought process due to dementia initiated on June 16, 2024. Intervention included to administer medications as ordered, and that the resident is able to recall one/ two or three instructions. However, the care plan revealed no evidence of a focus area documenting the resident's ability to self-administer medications. A review of the electronic health record revealed no evidence of an assessment for self-administration of medication. An observation was conducted on June 7, 2026 at 10:00 AM in the resident's room. A bottle of Nystatin topical powder 100,000 usp (United States Pharmacopeia) was observed on the resident's bedside table, noting to apply to navel for skin infection for 14 days dated October 15, 2025 with an expiration date of April 13, 2026. An interview was conducted with resident #5 on June 7, 2026 at 10:07 AM. Resident #5 stated that she did not know that the Nystatin powder was there or what it was for. An interview was conducted on June 7, 2026 AM with Certified Nursing Assistant (CNA/ staff #91). Staff #91 stated that medications should not be at bedside. Staff #91 further stated that if she did not know with certainty if something was a medication she would notify the nurse. Staff #91 stated that Nystatin was a medication and should not be at bedside. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on June 7, 2026 at 10:12 AM with Licensed Practical Nurse (LPN/ staff #56). Staff #56 stated that Nystatin was deemed a medication and that a doctor's note would be required for the medication to be authorized at the bedside table. Staff #56 stated that she was unsure if it required an assessment but stated that she was certain that it required a physician order. Staff #56 stated if medications are found at bedside, they are 'pulled' from the resident's room and reported to the DON (Director of Nursing). The LPN reviewed the medication and further stated that it was prescribed in October of 2025 and had a use-by date of April 13, 2026. She stated that the medication should have been disposed of. Staff #56 stated that the risk could include ingestion, if a resident was not oriented enough. An interview was conducted on June 9, 2026 at 8:34 AM with the DON, staff #83. The DON stated that a medication is anything with an active ingredient, ordered by a physician, but could also include over the counter medications. She further stated that medication administration routes could include oral, nasal, vaginal, intravenous, topical, and sublingual. The DON stated that the expectation for self-administration of medications was that an order must be in place, an assessment must be conducted, it must be care planned and the medication must be in a lock box. She stated that the aforementioned would be documented in the resident's electronic health record. The DON reviewed the electronic health record for resident #5 and stated that there were no current orders for the Nystatin and stated that there was no assessment or care plan entry for self-administration for medications. The DON stated that the general expectation for self-administration included the physician order, assessment, care planning and for a lock box to be in place to store the medication. The DON stated that the lock box is there so that medications cannot be accessed by other residents and further stated that individuals should not self-administer medications if they are cognitively impaired. Staff #83 further stated that no one in the facility is self-administering medications. The DON stated that the risk to the resident could include improper use or ingesting the medication. Staff #83 stated that she was aware that there was an issue regarding medications at bedside and that there is currently a PIP (performance improvement plan) in place, citing that education had already been completed by 99% of the nursing staff, with only 3 staff members remaining to be trained. -Regarding Resident #89: Resident #89 was admitted to the facility on [DATE], with diagnoses that included weakness, unstageable pressure ulcer of the sacral region, essential hypertension and glaucoma. A review of the Resident's hospital record dated June 2, 2026, revealed that over the last 1 to 2 months, the Resident had a slow decline in her mental status, and she was often confused and forgetful. The Resident's care plan dated June 4, 2026, revealed that the resident was at risk for functional self-care deficit and or functional mobility limitations, and at risk for skin impairment and or pressure injury. The interventions included to have physical therapy, occupational therapy, and speech therapy evaluation and treatment as per the provider orders, to encourage the Resident's participation to the fullest extent possible with each interaction, and to follow the facility policies and protocols for the prevention and treatment of skin breakdown. A review of the nursing health status progress note dated June 4, 2026, revealed that the Resident arrived to the facility for a 4-days of respite, and the Resident brought her own medications from home. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nurse practitioner progress notes dated June 5, 2026, revealed per the document that the Resident had a slow decline in her mental status, being forgetful and confused for 1 to 2 months. On June 7, 2026, at 8:47 AM, an observation was made, in the Resident's room by the vanity sink there was a white with red and green colored container. The container had a front label that read Treat Antifungal Powder For skin with a fungal infection. An interview was conducted on June 7, 2026, at 9:01 AM, with a Licensed Practical Nurse (LPN/Staff #56) who held the previously held container and stated that it was an antifungal powder and that somebody must have left it. She stated that the bottle belonged to Resident #89. Staff #56 stated that she would double check the Resident's order for antifungal orders. She also stated that she would double check if it was prescribed to the Resident. She stated that it should not have been left in the room because if the medication was left in the room, the resident might not be able to use it appropriately and that it could cause harm to the resident. At 9:06 AM, Staff #56 was observed by her medication cart, and after checking the orders in the electronic medical record, she stated that she did not see an order for the antifungal powder in the Resident's electronic medical record. An interview was conducted on June 9, 2026, at 8:16 AM with a Registered Nurse (RN/Staff #58). Staff #58 stated that she would not leave an antifungal powder at bedside unless there was a care plan to do so. She stated that some residents could have a care plan for self-administration of medication for medications such as an eye drop, and she stated that an antifungal powder is still a medication and she would not leave it at the bedside because the nurses apply the antifungal powder to the resident, a certified nursing assistant (CNA) could not apply the medication, and a resident could not apply it unless there was a care plan for self-administration. On June 9, 2026, at 8:34 AM, an interview was conducted with the Director of Nursing (DON/Staff #83). The DON stated that her expectation for self-administration of medications was that there must be an order, an assessment, must be care planned, the medications must be in a lock box, and the corresponding documentation would be housed in the resident's electronic health record. The DON stated that topicals are also considered medications. She also stated that unless assessed, ordered and care planned, antifungals should not be at bedside. The DON also reviewed the electronic record of Resident #89, and she stated that there were no orders in place for the antifungal, current or past orders, and she stated that there was no assessment in place for self-administration of medications for the Resident. The DON stated that the risk of leaving the medication at bedside could lead to ingesting and misuse. Furthermore, the DON stated that her expectation for self-administration is that an order, assessment, care planning and lock box are in place. She stated that the lock box is there so that medications could not be accessed by other residents. She also stated that individuals should not self-administer if they were cognitively impaired. She stated that no Resident in the facility was currently self-administering medications. -Regarding Resident #69 (medications unattended at bedside): Resident #69 was re-admitted on [DATE] with diagnoses that included vascular dementia, Type 2 Diabetes Mellitus, and major depressive disorder. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. A care plan initiated, August 5, 2025, revealed no evidence of a focus or interventions related to (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication self- administration. Further review of the care plan revealed the following: Diabetes focus with interventions that included medication as ordered by doctor. Antiplatelet medication with interventions to give medication as ordered. Clinical records dated August 5, 2025 through June 7, 2026, revealed no evidence of: A medication self-administration assessment or IDT meeting related to medication self-administration Physician orders for Medication Self Administration Medication self-administration in care planned focus or interventions Provider orders revealed the following: Eliquis 5 mg tablet, give tow times a day related to atherosclerotic heart disease, ordered August 5, 2025. Aspirin Chewable 81 mg, give 162 milligrams one time a day, ordered August 5, 2025. Vitamin D3, give 2000 units by mouth one time a day for supplement, ordered August 5, 2025. Glipizide 5 mg tablet, give 1 tablet by mouth one time a day for diabetes, dated May 28, 2026. Donepezil HCL 5 mg tablet, give 10mg by mouth one time a day ordered November 9, 2025. Losartan Potassium 50 mg tablet, give 2 one time a day for hypertension, ordered March 7, 2026. During an initial observation conducted on June 07, 2026 at 8:39 a.m. in the room of Resident #69, a meal tray was observed sitting unopened on the resident walker seat across from the resident's bed and a clear medication cup with 6 pills was sitting on the food tray. The resident was lying on the bed and no staff were in the room. The medications observed in the medication cup included 2 pink tablets, 1 clear yellow tablet, 1 oval white tablet, 1 round white tablet, and 1 white tablet. The surveyor went to the resident's door and asked staff or the medication nurse. An interview was conducted with Resident #69 at 8:44 a.m. who stated that staff usually wake her up to let her know that her meal is ready, and that staff leave her medications on her meal tray, then leave the room. An interview was conducted with a Registered Nurse (RN/staff #65) in the resident's room at 8:45 a.m., who stated that it is not following the policy to leave medications unattended in a resident's room. The RN also stated that nursing staff are expected to wait until the resident has swallowed all of the medications in front of nurse or med tech. The RN further stated that the risk of leaving mediations unattended at the bedside could result in medications taken outside of schedule which could lead to lower blood pressure or glucose levels, and also could increase the risk of resident's receiving medications too close together. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 8:45 a.m. with a Certified Medical Assistant/Medication Technician (CMA/Staff #54), who stated that she left the resident's medications at the bedside about 5 minutes previously. The CMA stated that she woke up the resident, told her about the medications, and left the medications in the resident's room. The CMA further stated that the facility expectation is to watch the residents take all medications before leaving the room. The CMA stated that she got caught up with another resident. The CMA identified the medications in the medication cup left at the bedside as: Pink- Eliquis for blood clot prevention. Pink Chewable aspirin Clear yellow - Vitamin d 3 White oval – Amlodipine Small round white – Glipizide for blood sugar White – Cardivol The CMA also stated that the risk of leaving medications unattended at the bedside could result in another resident taking the medication without staff knowing. Further review of the June 2026 revealed that that there were no orders for the medications that the CMA identified as Cardivol or Amlodipine in the medication cup that had been left unattended. However, the MAR revealed orders Donepezil and Losartan. An interview was conducted on June 9, 2026 at 1:40 p.m., with a Licensed Nursing Assistant (LNA/staff #14), who stated that residents should not be left alone in the room with medications at the bedside. The LNA stated that if she found medications at the bedside, she would stay with the medications, and ask another staff member to get the nurse. The LNA further stated that she was not aware of any residents in the facility that have been assessed to take keep their medications unattended at the bedside. The LNA also stated that Resident #69 would not be safe for self-administering medications, of for medications to be left unattended in her room. The LNA stated that there had been medications left unattended in the resident's room approximately 3 weeks ago, they were on the resident's bedside table, and when she pointed the medications out to the resident, the resident said she did not know that the medications had been left. The LNA stated that she removed the medications from the resident's bedside table and took them to the nurse. An interview was conducted on June 9, 2026 at 11:52 a.m. with a Licensed Practical Nurse (LPN/staff #22), who stated that medications are not to be left unattended at a resident's bedside per the facility policy. She also stated that residents would require an assessment for medication self-administration with discussions/education on medication storage, the care plan would be updated, and a physician order would be required. The LPN stated that the risk of leaving medications unattended at the bedside could result in another resident taking the medication. The LPN stated the Resident #69 was alert with a poor memory, and that medications were not supposed to be left unattended in the resident's room. The LPN reviewed the resident's records and stated that there was no evidence of a provider order, medication self-administration assessment, or care plan update for the resident to self-administer medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Director of Nursing (DON/staff #83) on June 9, 2026 at 1:36 p.m., who stated that in order for residents to self-administer medication there needs to be a provider order, an assessment, a care plan developed and the medications must be kept in a lock box. She further stated that all of this would be documented in the resident's clinical record. The DON also stated that she expected nursing staff and medication technicians to staff with each resident until the medication is administered. She also stated that it did not meet her expectation for medications to be left unattended at a resident's bedside. The DON stated that the risk of leaving medication unattended in a resident's room could result in someone else taking the medication, the medication could be spilled or dropped on the floor. -Regarding resident #22: Resident #22 was admitted on [DATE] with diagnoses including spastic hemiplegic cerebral palsy, epilepsy, and gastro-esophageal reflux disease without esophagitis. A review of IDT (interdisciplinary team) notes from September 26, 2019 through June 8, 2026 revealed no evidence that resident #22 was authorized to self-administer medications. A review of the comprehensive care plan dated September 27, 2019 revealed no evidence that resident #22 was authorized to self-administer medications. A review of the MDS (minimum data set) dated March 9, 2026 revealed a BIMS (brief interview of mental status) score of 14, which revealed intact cognition. A review of physician orders from May 1, 2026 through June 8, 2026 revealed no evidence of orders for medication self-administration. Further review of physicians orders revealed an order, dated August 14, 2024, for Tums Oral Tablet Chewable 500 mg (Calcium Carbonate (Antacid)). Give 2 tablets by mouth two times a day for GERD (gastro-esophageal reflux disease) without esophagitis. Additionally, an order was implemented May 16, 2023, for Calcium Carbonate Oral Tablet, give 750 mg by mouth every 6 hours as needed for Heart burn related to gastro-esophageal reflux disease without esophagitis. A review of assessments on June 8, 2026 within the electronic health record revealed no evidence that resident #22 was assessed to self-administer medications. During an observation conducted in resident #22's room on June 7, 2026 at 9:31 a.m., a plastic cup with 4.5 quarter-sized round tablets was observed to be present on the wooden dresser. Resident #22 stated the medication was Tums for her acid reflux and it was given to her by the nurse but she hadn't gotten around to taking them. During a follow up observation conducted in resident #22's room on June 7, 2026 at 11:23 a.m., the resident stated she had already taken the Tums in the plastic cup. Following this observation, an interview was conducted with a Certified Medication Aide (CMA/staff #54) on June 7, 2026 at 11:37 a.m Staff #54 stated that she had left a plastic cup of Tums in resident #22's room during morning medication pass and presented a bottle of Tums from the bottom drawer of the medication cart. Staff #54 further stated that resident #22 was able to self administer medications. Staff #54 reviewed the electronic health record and stated that the resident had an order for Tums and calcium carbonate tablets, but stated that she was unable to find self administration of (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications in the care plan, orders, or kardex. Staff #54 stated that the risk of leaving the Tums in the residents room include the possibility of other people ingesting the tablets when the resident isn't looking and the resident could choke on the medication if she does not chew it properly. A review of the medication administration record from June 1, 2026 to June 8, 2026 revealed Tums was administered to resident #22 on June 7, 2026 in the morning by Staff #54. An interview was conducted on June 9, 2026 at 8:34 a.m. with the Director of Nursing (DON/staff #83). The DON stated that the expectation for self-administration of medications is that there must be an order, an assessment, it must be care-planned and the medications must be in a lock box. The DON further stated that the corresponding documentation would be housed in the electronic health record. The DON also stated that she considered Tums to be a medication and that they should not be bedside unless the process of orders, assessment, care planning and lock box had been followed. The DON then reviewed the electronic health record for resident #22 and stated that the resident had an order for Tums but not for self-administration of Tums and further stated that there was no assessment and no care planning for self-administration. The DON stated the risks for medications at bedside include medication not being taken as prescribed, another resident taking them, or spilling. The DON also stated no one in the facility is currently self-administering medications. The facility's policy titled, Medication Labeling and Storage, dated January 1, 2024, revealed that the facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only personnel have access to keys. The facility's policy titled, Self-Administration of Medications, dated January 1, 2024, revealed as part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medication is safe and clinically appropriate for the resident. If the resident is deemed able to self-administer medications, the medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer are stored on a central medication cart or in the medication room. A licensed nurse transfers the unopened medication to the resident when the resident requests them. The policy further states any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. A policy titled, Medications: Administering Medications, revealed that medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. The individual administering medications verifies the resident's identity before giving the resident his/her medications. Resident's may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the nurse will return to the missed resident to administer the medication.

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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 record review, staff interviews, review of facility documents and policy, the facility failed to ensure one out of eighteen sampled residents (#47) received treatment and care related to insulin and blood pressure medications in accordance with the provider's order, professional standards of practice and the resident's comprehensive person-centered care plan. The deficient practice could place the residents' health at risk.Findings include:Resident #47 was readmitted to the facility on [DATE], with diagnoses that included essential hypertension, type 2 diabetes mellitus, and end stage renal disease requiring hemodialysis treatment. The Resident's care plan revealed that the Resident had diabetes mellitus and hypertension. The goal was for the Resident to have no complications related to his diagnoses of diabetes and hypertension. The interventions included for the staff to administer medications for diabetes and anti-hypertensive as ordered by the doctor, obtain fasting blood sugar test as ordered by the doctor, and obtain blood pressure readings under the same conditions each time and use the Resident's right arm to take his blood pressure.A review of the Resident's Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 12.0, indicating that the Resident cognition was moderately intact. The assessment also revealed that the Resident required hemodialysis treatment, and the Resident also used hypoglycemic, including insulin medications.A review of the physician's orders revealed the following orders:Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML, inject 15 unit subcutaneously one time a day for diabetes, and hold if blood glucose is less than 110. Isosorbide Mononitrate Oral Tablet ER (Extended Release) 24 Hour 30 MG (milligram). Give 2 tablets by mouth one time a day for hypertension, and hold if the systolic blood pressure is less than 110.A review of the April 2026 Medication Administration Record (MAR) revealed a transcribed physician order for Isosorbide Mononitrate Oral Tablet ER (Extended Release) 24 Hour 30 MG (milligram), give 2 tablets by mouth one time a day for hypertension, and hold if the systolic blood pressure is less than 110. The MAR also revealed that on April 15, 2026, the Resident's blood pressure was 99/63. The Resident's systolic blood pressure was 99. Despite an order to hold the medication if the systolic blood pressure is less than 110, the MAR revealed that the medication was administered to the Resident.A review of the May 2026 MAR revealed a transcribed physician orders for Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML, inject 15 unit subcutaneously one time a day for diabetes, and hold if blood glucose is less than 110 and Isosorbide Mononitrate Oral Tablet ER (Extended Release) 24 Hour 30 MG (milligram), give 2 tablets by mouth one time a day for hypertension, and hold if the systolic blood pressure is less than 110.Regarding the administration of these medications, the following were noted during the MAR review:Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML, inject 15 unit subcutaneously one time a day for diabetes, and hold if blood glucose is less than 110, the May 2026 MAR revealed that on:May 8, 2026, the Resident's blood glucose was 109, the insulin medication was administered to the Resident despite an order to hold if blood glucose is less than 110.May 12, 2026, the Resident's blood glucose was 95, the insulin medication was administered to the Resident despite an order to hold if blood glucose is less than 110.May 13, 2026, the Resident's blood glucose was 92, the insulin medication was administered to the Resident despite an order to hold if blood glucose is less than 110.May 19, 2026, the Resident's blood glucose was 85, the insulin medication was administered to the Resident despite an order to hold if blood glucose is less than 110.May 25, 2026, the Resident's blood glucose was 93, the insulin medication was administered to the Resident despite an order to hold if blood glucose is less than 110.May 27, 2026, the Resident's blood glucose was 103, the insulin medication was administered to the Resident despite an order to hold if blood glucose is less than 110.May 28, 2026, the Resident's blood glucose was 108, the insulin medication was administered to the Resident despite an order to hold if blood glucose is less than 110.May 29, 2026, the Resident's blood glucose was 105, the insulin medication was administered to the Resident (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	despite an order to hold if blood glucose is less than 110. Isosorbide Mononitrate Oral Tablet ER (Extended Release) 24 Hour 30 MG (milligram). Give 2 tablets by mouth one time a day for hypertension, and hold if the systolic blood pressure is less than 110, the May 2026 MAR revealed that on:May 9, 2026, the Resident's blood pressure was 105/63, the systolic blood pressure was 105, the blood pressure medication was administered to the Resident despite an order to hold if systolic blood pressure is less than 110.May 22, 2026, the Resident's blood pressure was 99/43, the systolic blood pressure was 99, the blood pressure medication was administered to the Resident despite an order to hold if systolic blood pressure is less than 110.A review of the June 2026 MAR revealed a transcribed physician order for Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML, inject 15 unit subcutaneously one time a day for diabetes, and hold if blood glucose is less than 110. The MAR also revealed that on June 4, 2026, the Resident's blood glucose was 96. Despite an order to hold the medication if the blood glucose is less than 110, the MAR revealed that the medication was administered to the Resident.An interview was conducted on June 9, 2026, at 8:16 AM with a Registered Nurse (RN/Staff #58). The RN stated that regarding medication administration process, she made sure to give the correct medications to the right resident, right time, and the right route. She stated that she should have the resident's medication profile screen open on her computer so she could check the medications, look at the Resident's recorded vital signs, and to check if anything could contraindicate the medication such as if the Resident might have low respiration, low blood pressure, and low pulse. She stated that depending on the type of medication, for example, if a Resident had a low blood pressure, she would hold the medication so the Resident's blood pressure would not go any lower. She also stated that regarding long acting insulin, with a parameter to hold if the blood sugar is less than 110, she stated that if the Resident's blood sugar is below the parameter order of 110, she would hold the insulin, so the Resident's blood sugar would not go lower, and because she was following the doctor's order. She further stated that if the insulin was administered outside the ordered parameter, the blood sugar would not go lower right away, but throughout the day the Resident's blood sugar could drop.During the interview with Staff #58, she stated that Resident #47 used long and short acting insulin for his diabetes. While Staff #58 was reviewing Resident #47's May 2026 MAR in the electronic medical record, she stated that on May 19, the Resident's blood sugar was 85, the Resident's insulin should not have been administered because the Resident's blood sugar was under 110, and the order was to hold if the blood sugar was under 110. She also stated that on May 8, May 12, May 13, May 16, May 19, May 25, May 27, May 28, and May 29, the insulin should not have been administered because it was not safe to give and it was outside the ordered parameter. She further stated that the scheduled time MD M found in the MAR meant before 6:00 AM during the night shift administration time schedule, and that the code 5 meant to hold and see the nurses' notes.An interview was conducted on June 9, 2026, at 9:04 AM with the Director of Nursing (DON/Staff #83). The DON stated that regarding the medication administration process, she expects her staff to follow the physician's orders, make sure the right medication, right dose, right time, right resident, right route, and right documentation were followed. She stated that if the process was not followed, there would be a potential for medication errors, the resident if medications are left at bedside could not take the medications, and the medication left at bedside could be taken by another resident. She also stated that if a medication was administered outside the ordered parameter, such as for insulin not to give if the blood sugar was less than 110, the result could lead to hypoglycemia.During the interview, the DON was looking at Resident #47's electronic medical record for the Resident's long acting insulin order, Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML, inject 15 unit subcutaneously one time a day for diabetes, and hold if blood glucose less than 110. While reviewing the Resident's MAR, the DON stated that on:May 8, the blood sugar was 109, the medication was administered, and the order was not followed.May 12, the blood sugar was 95, the medication was administered, and the order was not followed.May 13, the blood sugar was 92, the medication was administered, and the order was not followed.May 19, the blood sugar was 85, the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication was administered, and the order was not followed.May 25, the blood sugar was 93, the medication was administered, and the order was not followed.May 27, the blood sugar was 103, the medication was administered, and the order was not followed.May 28, the blood sugar was 108, the medication was administered, and the order was not followed.May 29, the blood sugar was 105, the medication was administered, and the order was not followed.June 4, the blood sugar was 96, the medication was administered outside the parameter, and the order was not followed.The DON stated that if the insulin medication was administered outside the ordered parameter, the Resident could get hypoglycemic (low blood sugar). The DON stated that the MID M schedule time in the MAR meant after midnight, and the night shift staff administers the medications between 12:15 AM to 6:00 AM. She stated that the insulin medications were administered between 5:00 AM-6:00 AM on night shift, and breakfast arrives at 7:00 AM. She also stated that the medication administered outside the ordered parameter did not meet her expectation. Further, the DON stated that she has a PIP (Performance Improvement Project) on medication administration which included passing medication, giving the right medications, following doctors' orders, and that the PIP was started on May 26, 2026. She stated that there was no specific medication being looked at for this PIP, and that she did not review Resident #47's insulin concerns because she was not aware of the Resident's insulin medication administration issues.A follow up interview was conducted on June 9, 2026, at 9:55 AM with the DON. After the DON reviewed Resident #47's MAR in the electronic medical record, the DON stated that Resident #47's order for Isosorbide Mononitrate Extended Release 24 Hour 30 MG, give 2 tablets by mouth one time a day for hypertension and to hold if the systolic blood pressure is less than 110, the DON stated that on:April 15, the blood pressure was 99/63, the medication was administered, and the order was not followed.May 9, the blood pressure was 105/63, the medication was administered, and the order was not followed.May 22, the blood pressure was 99/43, the medication was administered, and the order was not followed.The DON stated that her expectation was for the staff to follow the doctor's order and to hold the medication if the systolic blood pressure was less than 110, or if it was outside the parameter. She stated that the resident could have hypotension if the medication was given below a systolic blood pressure of 110. She also stated that hypotension is low blood pressure, and that a low blood pressure is lower than 110.Review of the facility policy titled Quality of Care: Medication and Treatment Orders in effect on January 1, 2024, revealed a statement that orders for medications and treatments will be consistent with principles of safe and effective order writing. Per policy, medications shall be administered only upon the written orders of a person duly licensed and authorized to prescribe such medications.

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	035233	A. Building B. Wing	06/10/2026

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Haven of Globe	1100 Monroe Street Globe, AZ 85501

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, observations, and review of facility policies and procedures, the facility failed to ensure that 2 out of 18 sampled residents (#1 and #2) received appropriate treatments and services to prevent urinary tract infections. The deficient practice could lead to a high risk of CAUTI (catheter-associated urinary tract infections), contamination transfer, tube obstruction or resident injury. Findings Include: -Regarding Resident #1 Resident #1 was admitted on [DATE] with diagnosis including type 2 diabetes mellites without complications, encephalopathy, end stage renal disease, bacteriuria, paroxysmal atrial fibrillation, dependence on renal dialysis, urinary tract infection, systemic inflammatory response syndrome of non-infectious origin, epilepsy, dementia with other behavioral disturbance, and obstructive and reflux uropathy. A review of the 5-day MDS (minimum data set) dated May 17, 2026 revealed a BIMS (brief interview of mental status) score of 6, indicated that the resident had severe cognitive impairment. The MDS further revealed that the resident had an indwelling catheter. A review of the physician orders revealed an order noting that the resident had Foley catheter, size 16 french and 10 cc (cubic centimeter) balloon dated May 14, 2026 as well as further orders noting catheter care with soap and water or wipes and directives to change the foley drainage bag as needed dated May 14, 2026. A review of the care plan revealed a focus area noting that the resident was on enhanced barrier precautions (EBP) due to a dialysis port/ catheter, PEG (percutaneous endoscopic gastrostomy)/ NG (nasogastric) tube and indwelling catheter, initiated May 16, 2026. An additional focus area revealed that the resident had an indwelling catheter, initiated May 16, 2026 and that interventions included that the catheter bag and tubing are to be positioned below the level of the bladder, changed as ordered, EBP in place and monitored for pain and or discomfort due to the catheter. An observation was conducted on June 8, 2026 at 11:56 AM while resident #1 was being transported from the secured unit to the main dining room. It was observed that the door from the secured unit was opened by a Certified Occupational Therapy Assistant (COTA/ staff #217) and that resident #1 was being pushed, via his wheelchair, through the door. It was subsequently observed that while pushing the resident through the door the wheelchair ran over the catheter bag and the resident said 'ouch'. The bag was observed to be dragging on the floor. While being transported to the main dining room, the bag continued to drag on the floor. Staff #217 positioned the resident against the back of the room and left the resident seated with the bag still touching the floor. An interview was conducted on June 8, 2026 at 11:59 AM with staff #217. Staff #217 stated that the expectation is that a catheter bag is properly situated and not touching the floor. She stated that when she picked up the patient up for lunch, he had already been transferred to the wheelchair and was given to her that way. Staff #217 was asked to observe the position of resident #1's catheter bag (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and stated that the catheter bag was touching the floor and should not have been. Staff #217 further stated that the risk to the resident could include the catheter bag getting yanked out, infection control issues and safety issues for the resident. An interview was conducted on June 9, 2026 at 7:21 AM with Registered Nurse (RN/ staff #58). Staff #58 stated that regarding catheter care, it was important to make sure that the bag is secured and off the ground. She stated that if a catheter bag was accidently rolled over, she would make sure to assess if there is any trauma and advise the provider and change the catheter out. She further stated that the risk for a bag being on the floor is infection. An interview was conducted on June 9, 2026 at 8:34 AM with the Director of Nursing (DON/ staff #83). Staff #83 stated that a catheter bag has to be kept off the floor, covered and safely secured. The DON further stated that the bag either had to be safely secured to the bed/ wheelchair/ Geri-chair. The DON stated that that if a catheter bag is run over, the expectation is that the catheter be changed. Staff #83 stated that during this event, the catheter bag was not changed immediately, but it was changed later in the day. The DON stated that the risk for a catheter bag being on the floor could include infection. Staff #217 further stated that anyone on the nursing or therapy team are responsible to ensure that the catheter bags are safely secured and covered for privacy. -Regarding resident #2: Resident #2 was admitted on [DATE] with diagnoses including displaced fracture of greater tuberosity of left humerus, chronic kidney disease, obstructive and reflux uropathy, and retention of urine. A review of the MDS (minimum data set) dated April 10, 2026 revealed a BIMS (brief interview of mental status) score of 9, which revealed moderate cognitive impairment. Further MDS record review revealed resident #2 had an indwelling catheter. A review of the Catheter Evaluation dated April 24, 2026 revealed the resident's medical condition/diagnosis of Obstructive Uropathy-Urinary Tract Obstruction supported the use of a catheter. A review of the residents care plan dated April 27, 2026, revealed a focus area including having an indwelling catheter related to obstructive uropathy, enhanced barrier precautions related to indwelling catheter, being at risk for functional self care deficits and/or functional mobility limitation related to urinary catheter use, and being at risk for skin impairment related to foley catheter use. A review of active physician orders on June 8, 2026 revealed orders for changing foley catheter as needed, change foley drainage bag as needed for poor drainage, leaking, soilage, blocking, or as ordered by provider, and to provide catheter care with soap and water or wipe, and that resident was on enhanced barrier precautions for catheter. During an observation conducted in resident #2's room on June 7, 2026 at 10:30 a.m., the resident was laying in bed and the catheter bag was observed making direct contact with the floor while the bed was in the lowest position. During an interview conducted in resident #2's room on June 7, 2026 at 10:31 a.m., resident #2 stated that the Certified Nursing Assistant (CNA) emptied the catheter bag a couple of hours ago and he did (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not know if the catheter bag had been in the same position since then. During an observation conducted in resident #2's room on June 8, 2026 at 1:59 p.m., the resident was laying in bed and the catheter bag was observed making direct contact with the floor while the bed was in the lowest position. An interview was conducted on June 8, 2026 at 2:02 p.m. with CNA (staff #43). Staff #43 stated that resident #2 liked to sit on the side of the bed often and would move around as needed and wanted. He further stated that he only knows of the blood being present in his urine every once in a while and he would tell the nurses if there was anything wrong regarding the catheter. The CNA was then called to the floor to provide care and no further questioning was conducted. An interview was conducted on June 8, 2026 at 2:18 p.m. with Registered Nurse (RN/staff #65). Staff #65 stated that the resident has a difficult time with his catheter, often being angry, dragging the catheter bag around, leaving it on the floor, and attempting to rip it out. Staff #65 also stated that the implemented standards of practice for infection control procedures regarding catheters includes cleansing the area and changing any parts of the catheter as needed. Staff #65 further stated that if the resident's bed was in the lowest position and the catheter bag was touching the floor she would implement the typical interventions as documented in the resident's care plan while keeping the bag below the bladder. During an interview conducted in resident #2's room on June 8, 2026 at 2:50 p.m., staff #65 stated that resident #2's catheter bag was making contact with the floor and the bag should not be on the floor. Staff #65 also stated the process to correct it would be to raise the height of the bed and be more vigilant of the bag for infection control purposes. Staff #65 then woke resident #2, asked if he was okay, and raised the height of the bed. Staff #65 also stated that she looks in on the residents three times a shift on average and had recently checked his blood glucose but could not recall seeing the catheter bag on the floor and stated that she was questioning herself if it was on the floor during that time. Staff #65 further stated the CNA's are more involved by being with the residents a majority of the shift and that the risk of the catheter bag being on the floor would be infection, death from sepsis, bacteremia, change of mentation, fever, and long term renal failure. During an interview conducted on June 8, 2026 at 3:08 p.m. with Director of Nursing (DON/staff #83) and RN #65, the DON stated that the process of seeing a catheter bag on the floor would be to pick it up, clean it, and make sure it is no longer on the floor. The DON further stated that it is the responsibility of all nursing staff to continue monitoring the catheter and that the risk of a catheter bag being on the floor would be an infection. The DON then called CNA (staff #43) into the DON's office to conduct further interviewing. During an interview conducted on June 8, 2026 at 3:19 p.m. with staff #43, the CNA stated that he had not seen any issues with resident #2's catheter and stated that he conducts monitoring before and after each meal. Staff #43 also stated that catheter care consists of wearing personal protective equipment in accordance with enhanced barrier precautions, properly cleaning the area of catheter insertion, and ensuring the bag is below the bladder. Staff #43 further stated that the risk of the catheter bag being on the floor would be infection. The interview was then moved to resident #2's room, where the DON stated that the anchor for the catheter bag was broken, that the drainage spout was touching the floor, and she would have staff #43 replace the catheter bag. Staff #43 then explained that he was going to change the bag completely and place the bag on the bed frame where it would not be above the bladder and also not touch the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the treatment administration record from May 1, 2026 to June 8, 2026, revealed that catheter care was conducted two times every day, with no replacement of the catheter bag or catheter tubing. The facilities policy titled, Infection Control Policy and Procedures, dated 2013, revealed that Haven Health takes an Interdisciplinary Team (IDT) approach to infection control involving the Physician, Director of Nursing (DON), Housekeeping, Dietary, Maintenance, as well as direct care staff. The policy further states all facility staff will be educated on hand hygiene, infection control, and isolation precautions on hire and annually. The facilities policy titled, Urinary/Renal Conditions: Catheter Care, Urinary, dated January 1, 2024, revealed to use aseptic technique when handling or manipulating the drainage system, to be sure catheter tubing and drainage bag are kept off the floor, and to change catheters and drainage bags based on clinical indication such as infection, obstruction or when the closed system is compromised.