STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Lakeside	3401 North Lockwood Drive Lakeside, AZ 85929

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, review of facility documents and policy, [NAME] Nursing Drug Handbook, and Medlineplus.gov website, the facility failed to ensure medications for four residents (#24, #64, #9, #86) were administered as ordered by the physician. The deficient practice could place residents safety at risk and could result in resident's not receiving the treatment that they need.Number of residents sampled: 20Number of residents cited: 4Findings include:-Resident #24 was admitted to the facility on [DATE] with diagnoses that included hypertension, depression and Non-Alzheimer's Dementia.The care plan dated March 17, 2023 revealed the resident was on opiate medication and was at risk for pain related to pain and history of right hip fracture and generalized discomfort. Intervention included to administer medications as ordered.Another care plan dated March 18, 2023 revealed resident use antidepressant medication related to Depression. The interventions included to give antidepressant medications as ordered by the physician and monitor/document side effects and effectiveness.A review of Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12.0, moderately impaired.On September 15, 2025 at 7:36 AM, a medication administration observation was conducted with Licensed Practical Nurse (LPN)/Staff #89. The following medications were dispensed: Sertraline (Antidepressant) 50 mg (milligram) one tablet, lisinopril (Antihypertensive)10 mg one tablet and lidocaine patch (topical anesthetic) 4% one patch. At 7:36 AM, Staff #89 stated there were two pills and one patch and at 7:37 AM, the medications were administered to the resident by mouth. At 7:38 AM, Staff #89 asked the Resident where would the Resident like the patch to be applied on. Staff #89 then immediately removed a white patch from the resident's left lower leg, folded it in half and discarded it; and stated that the folded white patch was just removed from the Resident's left lower leg. Staff #89 then applied the new patch to the shin area of the resident's left lower leg. Regarding Lidocaine External Patch 4%:The physician order dated September 30, 2025 revealed an order for Lidocaine External Patch 4% applied to knee topically one time a day for pain and remove per schedule. However, the order did not include a schedule when to apply and when to remove the patch.A review of Medication Administration Record (MAR) for September 2025 revealed that Lidocaine External Patch 4% was transcribed in the MAR to be applied at 8:00 AM and to be removed at 8:00 PM. The documentation in the MAR included check marks and initials on the boxes from September 1 through September 14, 2025 indicating the Lidocaine patch was applied and removed as scheduled. Further, the documentation included that the lidocaine patch was applied on September 14, 2025 at 8:00 AM and removed on September 14, 2025 at 8:00 PM.However, there was a patch that was still present on the resident's left lower leg that was removed by staff #89 only during the medication administration observation on September 15, 2025 at 7:38 AM. The clinical record revealed no evidence of any physician order regarding the schedule of application and removal time for the lidocaine patch; and that, the physician was notified.Regarding Sertraline HCl tablet 100 mg:A physician order dated September 4, 2025 revealed an order for Sertraline HCl (Hydrochloride) tablet 100 mg give one tablet by mouth one time a day for sad statements related to depression.The order for Sertraline was transcribed onto the MAR for September 2025.There was no evidence found in the clinical record that (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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	when multiple antihypertensives are prescribed simultaneously; when discontinuing, gradual tapering may be required to avoid adverse consequences caused by abrupt cessation; and report pertinent lab results to the provider.The provider progress notes dated June 2, 2025 revealed that the resident continued to take Lasix for edema and was complaining about legs still edematous and weeping. Per the documentation, the provider planned to consult a lymphedema clinic and increase the Lasix (diuretic and brand name for Furosemide) to 20 mg twice a day.A review of the Quarterly MDS dated [DATE] revealed a BIMS score of 15.0 indicating the resident had intact cognition. The physician order summary revealed an order for Furosemide (diuretic) tablet 20 mg give 1 tablet by mouth two times a day related to edema (order date of May 28, 2025) with no scheduled times for administration.Review of the MAR for September 2025 revealed a transcribed order for for Furosemide tablet 20 mg give 1 tablet by mouth two times a day related to edema scheduled to be administered at 8:00 AM and 12:00 PM (approximately 4 hours apart).However, there was no evidence found in the clinical record of any physician order that indicated Furosemide were to be administered at 8:00 AM and 12:00 PM (approximately 4 hours apart). Continued review of the MAR for September 2025 revealed that Furosemide was administered on September 15, 2025 at 8:00 AM.There was also no evidence found that the order for Furosemide was clarified with the physician until September 16, 2025. A review of progress note dated September 16, 2025 at 1:21 PM revealed that the DON communicated with the physician regarding the furosemide order to be administered at 0800 and 1200. The physician clarified stating that for this resident it is clinically appropriate medication administration schedule. There have been no concerns noted in the pharmacy review additionally.On September 15, 2025 at 11:26 AM, a medication administration observation was conducted with LPN/Staff #47 who dispensed Furosemide 20 mg and administered the medication to the resident at 11:28 AM (approximately 3 1/2 hours from the last administration)An interview was conducted on September 15, 2025 at 2:41 PM with a Registered Nurse (RN/ Staff #54) who when a diuretic such as Furosemide is ordered once daily, it is usually given around 7:00 or 8:00 AM; and, if it is ordered for twice daily, it is usually administered at 8:00 AM and 4:00 PM to avoid the resident being up all night urinating. The RN said that giving Furosemide at 8:00 AM and again at 12:00 PM could cause excessive urination and increase the risk of dehydration. Further, she stated she was not aware of any residents receiving Furosemide on an 8:00 AM and 12:00 PM schedule. On September 16, 2025, at 8:40 AM, a phone interview was conducted with the provider (Staff #450) who stated that lidocaine patches are ordered either once daily or as needed, and the pharmacy label includes instructions for application. The provider said that there was no specific order to remove the patch because it was considered common sense that it should not be left on for days. Further, the provider said that the expectation was that staff would remove it appropriately; and that, the facility follows standard protocol for lidocaine patch use as directed by the pharmacy. Regarding Furosemide, the provider stated that the standard of practice for a twice daily order of Furosemide was that the drug is administered at 8:00 AM and evening, i.e., one dose in the morning and the another dose in the evening. Further, the provider said that he does not advice Furosemide to be taken in the morning and at noon.A phone interview was conducted with the pharmacist (Staff #480) on September 16, 2025 at 9:20 AM. The pharmacist stated that the lidocaine 4% patch was a facility/house stock so the pharmacy do not deliver Lidocaine 4% patch to the facility. Regarding Furosemide, the pharmacist stated that the administration times for Furosemide was dependent on the facility. She stated that the pharmacy does not enter administration times unless provider specifies this in their order. The pharmacist said that Furosemide was usually administered 6 to 8 hours apart and not less than 6 to 8 hours; and that, each resident reaction to furosemide was different such as it might cause a blood pressure drop, dizziness or frequent urination. Further, the pharmacist said that if administered too often or continuously, it can cause dehydration.On September 16, 2025, at 9:41 AM, an interview was conducted with an LPN orientee (Staff #503) and an LPN (Staff #47). Staff #47 stated that diuretics like Lasix (Furosemide) remove excess water from the body through the kidneys. She stated that she (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administers the medication according to the physician's schedule which is sometimes in the morning or afternoon. Staff #47 said that if Lasix was ordered for twice daily, the second dose was usually given at 4:00 PM; and, this timing allows residents to sleep through the night without frequent urination. Staff #47 stated that Resident #86 had a physician's order for Furosemide 20 mg twice a day, scheduled at 8:00 AM and 12:00 PM. She said that this schedule was based on the provider's instructions and it might have been requested by the resident. Staff #47 said that although she would typically question a twice-daily Furosemide order set for 8:00 AM and 12:00 PM, she had been administering it that way to Resident #86 since the order was written in May 2025. She also stated the provider had previously informed her that the resident preferred the medication be given at those times.In an interview conducted on September 16, 2025, at 10:01 AM, the Director of Nursing (DON/Staff #80) who stated that the expectation during medication administration for all staff, including himself, was to follow facility policy, review the order, and follow the physician's instructions. Regarding Furosemide, the DON stated that Furosemide is given as ordered by the physician. The DON said that if Furosemide was ordered for twice a day, without specific times, the expectation was for staff to follow the doctor's order; and that, the schedule for administration for medications was set in their electronic record. The DON stated that if Furosemide was ordered for twice a day, it will be given in the morning and late afternoon between 3:00 PM and 6:00 PM to facilitate restful sleep. However, he stated that his nursing judgement was not the policy. The DON stated that the expectation was for staff to follow their policy and the doctor's order to give furosemide twice a day; and in the case of Resident #86, to give the second dose of Furosemide 4 hours later. Regarding the lidocaine patch, the DON said that staff were expected to follow the doctor's order; and, failure to do so could result in the resident not receiving a needed medication. He stated that the lidocaine patch is a topical pain reliever applied by either a nurse or a Certified Medication Assistant (CMA) to the area specified in the physician's order; and that, if the physician orders removal of the patch, staff are expected to follow that order. However, the DON said that if no removal instructions were provided, the nurse may use their clinical judgment or follow the manufacturer's guidelines.During an observation at the nurses' station conducted with the DON on September 16, 2025 at 10:23 AM, the DON pulled out an unopened lidocaine patch in its original package from the medication cart. On the front side of the 4% Lidocaine Patch Pain Relief package revealed the following written information:For Single-UseEasy to Apply and RemoveStay-Put Flexible PatchNo-Mess ApplicationLasts Up to 12 HoursAnd, on the back side of the 4% Lidocaine Patch package, the direction revealed the following information:Apply sticky side of patch to affected areaUse one patch for up to 12 hoursDiscard patch after single useIn a later interview with the DON conducted on September 16, 2025 at 1:03 PM, the DON sated that the Furosemide order for Resident #86 was entered by the provider and all orders for resident #86 were reviewed by their pharmacy. The DON provided a copy of a progress note dated June 2, 2025 from the clinical record of Resident #86 and stated that the provider will increase Resident's Furosemide to 20 mg twice a day; however, the documentation of the order in the progress note did not indicate a specific instruction for Furosemide to be administered at 8:00 AM and at 12:00 PM. The DON stated that he clarified with the provider today, September 16, 2025 the Furosemide order and documented this in the clinical record. According to [NAME] Nursing Drug Handbook, Furosemide is used for the treatment associated with heart failure and renal/hepatic disease; and acute pulmonary edema. The pharmacokinetics (study of how the body interacts with administered substances for the entire duration of exposure) of the drug when taken by mouth are: the onset of the drug when taken orally is 30 to 60 minutes, the drug peaks in 1 to 2 hours, and the duration is 6 to 8 hours. It also included a half-life of 30-90 minutes. Black Box Alert included that large doses can lead to profound diuresis with water and electrolyte depletion. Expected side effects included increased urinary frequency/volume, electrolyte imbalance, dizziness, light-headedness, blurred vision, diaphoresis and blurred vision.The medlineplus.gov website last revised on June 15, 2021 included that nonprescription lidocaine transdermal comes as a 4% patch to (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	apply to the skin. It is applied up to 3 times daily and for no more than 8 hours per application. Use nonprescription lidocaine patches exactly as directed. Do not use more or less of it or use it more often or for a longer period of time than directed by the package instructions. The doctor will tell you how many lidocaine patches or topical systems you may use at one time and the length of time you may wear the patches. Applying too many patches or topical systems or leaving them on for too long may cause serious side effects.Review of facility policy on Medication and Treatment Orders, effective January 1, 2024 revealed that orders for medications and treatments will be consistent with principles of safe and effective order writing. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribed such medications in this state. Drug and biological orders must be recorded on the physician's order sheet in the resident's chart. Such orders are reviewed by the consultant pharmacist on a monthly basis.Review of facility policy titled, F014-Medications: Medication Administration Schedule, effective January 1, 2024 revealed medication are administered according to established scheduled and following routine schedule. For ordered times of BID (two times a day), policy did not indicate what time in a.m. and in p.m. should the medication be given. Per the policy, scheduled medications are administered within one (1) hour of their prescribed time, unless otherwise specified. A physician's order for specific times supersedes any routine schedule. Residents may request alternate medication schedules. Such times must be documented on the resident's medication administration record and care plan.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on personnel file review, staff interview, and facility documentation and policy review, the facility failed to ensure the activities program was directed by a qualified professional. The deficient practice could result in the activities provided not meeting the assessed needs of the residents. Findings include: A review of the personnel file for the Activities Director (staff #24) revealed staff #24 was hired on October 18, 2024. Review of staff #24's job description revealed that as the Activity Manager she directs the development, implementation, supervision, and ongoing evaluation of the activities program. This includes the completion of the activities component of the comprehensive assessment along with the comprehensive care plan goals and approaches. The job description indicated that the Activity Manager oversees the direction of the activity program to include scheduling of activities, both individual and groups, and the implementation of such programs. The Activity Manager directs the monitoring of the residents' responses as well as the evaluation of responses to the programs to determine if the activities meet the assessed needs. Further review of the job description revealed that the facility's minimum requirement for the Activities Director listed the following:- background check- fingerprint clearance card- TB (tuberculosis) clearance- employee health screening post hire- speak and understand English Additionally, the facility's job description did not reflect the requirements indicated in the State Operations Manual for the Activity Director position. Review of staff #24's resume revealed that she held the position of Senior Research Associate/Administrative Director from 2018 until her employment at the facility. The resume also indicated that her educational background are as follows:- Master in Education- Bachelors in Arts (Music Therapy/Music Education/Psychology) Further review of staff #24's resume did not indicate that her education, background, and experience met the requirements indicated in the State Operations Manual for the Activity Director position. Staff #24's personnel file revealed she submitted an application to initiate Activity Director Certification on June 11, 2025. A copy of the email dated July 11, 2025 accompanying the application verification for Activity Director Certification had a handwritten note dated September 15, 2025 stated that an essay was submitted and is under review for her certification application. An interview with Human Resource (HR/staff #70) was conducted on September 16, 2025 at 9:47 a.m. Staff # 70 stated that the Activity Director (staff #24) has an extensive background which included a BA (Bachelor in Arts) in Music Therapy, Music Education, and Psychology. Additionally, staff #24 held the position of Senior Research Associate from 2018-2024. Per HR, staff #24 applied for Activity Director Certification on June 11, 2025. Staff #70 said that to his knowledge staff #24 has not held an activities position prior to her current position as the Activity Director. HR stated that staff #24's position requires her to oversee activities for their residents. On September 16, 2025 at approximately 4:20 p.m., an interview with staff #24 was attempted. However, the receptionist was unable to help the survey team locate the staff member. A follow-up interview with HR (staff #70) was conducted on September 17, 2025 at 8:02 a.m. Staff #70 stated that during the hiring process they use the job description to determine the qualifications needed for the position. HR stated that they try to stay within the parameters, ensure that the candidate has experience, and have the appropriate license/credentials required, and history in employment and education. Staff #70 stated that this is important to ensure that the member can function in the position, do the job correctly, are responsible to do the duties, and ensure resident safety/care/good quality of life. HR said that the possible impact of a staff not having the appropriate requirements for the position is that it can potentially lead to poor quality of services, and not meet the criteria for the position. An interview with the Director of Nursing (DON/staff #80) was conducted on September 17, 2025 at 8:35 a.m. Staff #80 stated that candidates are vetted during hiring and interview process to determine if they are a fit and qualified for the position. The DON also noted that the facility has 90-days after hire to evaluate the member's abilities to perform the job. Staff #80 stated that his expectation with regards to hiring is that they follow the policy with the assumption that it follows state and federal (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, facility documents and policy review, the facility failed to ensure current nurse staffing information was accurate for actual hours worked by licensed and unlicensed direct care nursing staff and that the census was updated daily to reflect the actual number of residents. The deficient practice could result in residents and visitors not being informed of accurate and current staffing information and census. Findings include: The PBJ (Payroll-Based Journal) Staffing Data Report revealed that the facility consistently triggered for excessively low weekend staffing the last two quarters in 2024 and the first three quarters of 2025. Per the report, submitted weekend data was excessively low. A weekend date was picked from each of the quarters that triggered for excessively low weekend for review. -Regarding June 30, 2024 Review of the June 30, 2024 Staff Posting indicated the following:-5 CNAs (Certified Nursing Assistant) scheduled for the 6:00 p.m. - 6:00 a.m. shift-Total hours worked by CNAs on the 6:00 p.m. - 6:00 a.m. shift = 60 hours However, review of the signed Staffing Sheet (daily staffing assignment) for June 30, 2024 revealed that:-only 4 CNAs reported to work for the NOC (nocturnal = night) shift (6:00 p.m. - 6 a.m.) - 1 scheduled CNA called off Additionally, review of the punch details for June 30, 2025 revealed:-4 CNAs worked the 6:00 p.m. - 6 a.m. shift-Total of actual hours worked by the CNAs for that shift = 50.23 hours. -Regarding September 21, 2024 Review of the September 30, 2024 Staff Posting indicated the following:-No Valets for the 6:00 a.m. - 6:00 p.m. shift -1 RN (Registered Nurse) for the 6:00 p.m. - 6:00 a.m. shift-Total hours worked by RN on 6:00 p.m. - 6:00 a.m. shift = 12 hours-2 LPNs (Licensed Practical Nurse) for the 6:00 p.m. - 6:00 a.m. shift-Total hours worked by LPN on 6:00 p.m. - 6:00 a.m. shift = 24 hours-5 CNAs for the 6:00 p.m. - 6:00 a.m. shift-Total hours worked by CNAs on 6:00 p.m. - 6:00 a.m. shift = 48 hours However, review of the signed Staffing Sheet for September 21, 2024 licensed nurse listed for the 6:00 p.m. - 6:00 a.m. shift, compared to the punch details revealed that the three individuals were all LPNs. Furthermore, review of the punch details for September 21, 2024 revealed the following:-2 valets on 6:00 a.m. - 6:00 p.m. shift-Total of actual hours worked for Valets on 6:00 a.m. - 6:00 p.m. shift = 6.69 hours-No RN on shift for the 6:00 p.m. - 6:00 a.m. shift-3 LPNs on shift for the 6:00 p.m. - 6:00 a.m. shift-Total of actual hours worked by LPNs on 6:00 p.m. - 6:00 a.m. shift = 37.74 hours-4 CNAs on shift for the 6:00 p.m. - 6:00 a.m. shift-Total of actual hours worked by CNAs on 6:00 p.m. - 6:00 a.m. shift = 49.49 hours -Regarding December 29, 2024 Review of the December 30, 2024 Staff Posting indicated the following:-2LPNs for the 6:00 a.m. - 6:00 p.m. shift -Total hours worked by LPN on 6:00 a.m. - 6:00 p.m. shift = 24 hours-5 CNAs for the 6:00 p.m. - 6:00 a.m. shift-Total hours worked by CNAs on 6:00 p.m. - 6:00 a.m. shift = 60 hours However, review of the signed assignment sheet for December 29, 2024 revealed:-1 LPN called off for the 6:00 a.m. - 6:00 p.m. shift -An RN was erroneously annotated as an LPN-1 CNA called off for the 6:00 p.m. - 6:00 a.m. shift Furthermore, review of the punch details for December 29, 2024 revealed:-1 LPN for the 6:00 a.m. - 6:00 p.m. shift -Total of actual hours worked by LPN on 6:00 a.m. - 6:00 p.m. shift = 12.40 hours-4 CNAs for the 6:00 p.m. - 6:00 a.m. shift-Total of actual hours worked by CNAs on 6:00 p.m. - 6:00 a.m. shift = 41 hours -Regarding March 8, 2025 Review of the March 8, 2025 Staff Posting indicated the following:-9 CNAs for the 6:00 a.m. - 6:00 p.m. shift -Total hours worked by CNAs on 6:00 a.m. - 6:00 p.m. shift = 108 hours-5 Valets for 6:00 a.m. - 6:00 p.m. shift -Total hours worked by valets on 6:00 a.m. - 6:00 p.m. shift = 60 hours-6 CNAs for the 6:00 p.m. - 6:00 a.m. shift-Total hours worked by CNAs on 6:00 p.m. - 6:00 a.m. shift = 72 hours However, review of the signed assignment sheet for March 8, 2025 revealed:-7 CNAs scheduled for the 6:00 a.m. - 6:00 p.m. shift -1 [NAME] called off for the 6:00 a.m. - 6:00 p.m. shift -1 CNA called off for the 6:00 p.m. - 6:00 a.m. shift Furthermore, review of the punch details for the March 8, 2025 revealed:-8 CNAs for the 6:00 a.m. - 6:00 p.m. shift -Total of actual hours worked by CNAs on 6:00 a.m. - 6:00 p.m. shift = 95.39 hours-4 valets for the 6:00 a.m. - 6:00 p.m. shift -Total of actual hours worked by [NAME] on 6:00 a.m. - 6:00 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Haven of Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 North Lockwood Drive Lakeside, AZ 85929	

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p.m. shift = 42.61 hours-1 CNA scheduled for the 6:00 p.m. - 6:00 a.m. shift, worked the 6:00 a.m. - 6:00 p.m. shift instead-4 CNAs for the 6:00 p.m. - 6:00 a.m. shift -Total of actual hours worked by CNAs on 6:00 p.m. - 6:00 a.m. shift = 48.76 hours -Regarding May 4, 2025 Review of the May 4, 2025 Staff Posting indicated the following:-Total hours worked by CMAs on 6:00 a.m. - 6:00 p.m. shift = 24 hours- 9 CNAs for the 6:00 a.m. - 6:00 p.m. shift-Total hours worked by CNAs on 6:00 a.m. - 6:00 p.m. shift = 108 hours However, review of the signed assignment sheet for May 4, 2025 revealed:- 2 CNAs called off for the 6:00 a.m. - 6:00 p.m. shift Furthermore, review of the punch details for the May 4, 2025 revealed:-Total of actual hours worked by CMAs on 6:00 a.m. - 6:00 p.m. shift = 22.80 hours-8 CNAs for 6:00 a.m. - 6:00 p.m. shift-Total of actual hours worked by CNAs on 6:00 a.m. - 6:00 p.m. shift = 91.86 hours-Total of actual hours worked by [NAME] on 6:00 a.m. - 6:00 p.m. shift = 11.47 hours The facility assessment updated August 15, 2025 revealed that the facility was licensed to care for 112 residents, had an average daily census of 90 with 15-35 of the census being from short term stays and an average admission and discharges of 1-8 over the weekend. Staffing plan included the following: - full time Director of Nursing- Up to 5 nurses/CMA (Certified Medical Assistant) on day shift (6:00 a.m. - 6:00 p.m.)- Up to 5 nurses/CMA on night shift (6:00 p.m. - 6:00 a.m.)- Up to 12 direct care staff for day shift (6:00 a.m. - 6:00 p.m.)- Up to 8 direct care staff for night shift (6:00 p.m. - 6:00 a.m.) During the entrance conference conducted on September 14, 2025 at 11:06 a.m., it was observed that the Daily Staff Posting located at the reception desk did not contain the census. Additionally, during the entrance conference conducted on September 14, 2025 at 11:06 a.m., the Charge Nurse (staff #14) was unable to state the current census. During an interaction with the Executive Director (ED/staff #411) on September 14, 2025 at approximately 1:15 p.m., staff #411, stated that the census was 89. However, review of the facility completed CMS-671 form dated September 14, 2025 revealed that the census was 86. During clarification with the ED (staff #411) on September 14, 2025 at approximately 3:30 p.m., staff #411 confirmed that the census was 86. The ED stated that the correct census was provided by their Business Office Manager. An observation of the Daily Staff Posting located at the reception desk was conducted on September 15, 2025 at 8:14 a.m. Although, the Staff Posting posted was for that day. The posting did not contain the census. A follow-up observation of the Daily Staff Posting conducted on September 15, 2025 at 9:15 a.m. revealed that the posting was updated with the census indicating that it was 85. A telephonic interview with the Staffing Coordinator (staff #7) was conducted on September 17, 2025 at 7:38 a.m. According to staff #7 the Daily Staff Posting is updated by either the Business Office Manager or the Receptionist. The Staffing Coordinator said that she staffs the facility based on the yearly review of the Director of Nursing (DON) and acuity. Staff #7 indicated that manning the facility accurately is important in order to meet the needs of the residents and not have long wait times. An interview with Human Resource (HR/staff #70) was conducted on September 17, 2025 at 8:02 a.m. Staff #70 stated that the receptionist updates the provided staffing sheets with the accurate information based on the actual numbers of staff that shows up for shift. According to HR, it is important for the Daily Staff Posting to be accurately posted so that the public can know how many people are caring for their family (residents). Additionally, accurate posting is important for compliance. Staff #70 said that the impact of not having accurate Daily Staff Posting is that the facility would be out of compliance. Furthermore, HR stated that inaccurate Daily Staff Posting could give the public a perception of dishonesty. The Director of Nursing (DON/staff #80) was interviewed on September 17, 2025 at 8:34 a.m. According to staff #80 the Daily Staff Posting is posted at the front to indicate how many staff are working the floor and the census. The DON stated that accurately posted Daily Staff Posting is important in order to be compliant with policies. Staff #80 said that the impact of inaccurate/incomplete Daily Staff Posting is that it would impact the facility's compliance with policies.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, review of facility documentation and policy, [NAME] Nursing Drug Handbook and Medlineplus.gov website, the facility failed to ensure that medication error rates were not five percent or greater. The deficient practice could place residents safety at risk.Findings include:-Resident #24 was admitted to the facility on [DATE] with diagnoses that included hypertension, depression and Non-Alzheimer's Dementia.The care plan dated March 17, 2023 revealed the resident was on opiate medication and was at risk for pain related to pain and history of right hip fracture and generalized discomfort. Intervention included to administer medications as ordered.Another care plan dated March 18, 2023 revealed resident use antidepressant medication related to Depression. The interventions included to give antidepressant medications as ordered by the physician and monitor/document side effects and effectiveness.On September 15, 2025 at 7:36 AM, a medication administration observation was conducted with Licensed Practical Nurse (LPN)/Staff #89. The following medications were dispensed: Sertraline (Antidepressant) 50 mg (milligram) one tablet, lisinopril (Antihypertensive)10 mg one tablet and lidocaine patch (topical anesthetic) 4% one patch. At 7:36 AM, Staff #89 stated there were two pills and one patch and at 7:37 AM, the medications were administered to the resident by mouth. At 7:38 AM, Staff #89 asked the Resident where would the Resident like the patch to be applied on. Staff #89 then immediately removed a white patch from the resident's left lower leg, folded it in half and discarded it; and stated that the folded white patch was just removed from the Resident's left lower leg. Staff #89 then applied the new patch to the shin area of the resident's left lower leg.Regarding Lidocaine External Patch 4 %:The physician order dated September 30, 2025 revealed an order for Lidocaine External Patch 4% applied to knee topically one time a day for pain and remove per schedule. However, the order did not include a schedule when to apply and when to remove the patch.A review of Medication Administration Record (MAR) for September 2025 revealed that Lidocaine External Patch 4% was transcribed in the MAR to be applied at 8:00 AM and to be removed at 8:00 PM. The documentation in the MAR included check marks and initials on the boxes from September 1 through September 14, 2025 indicating the Lidocaine patch was applied and removed as scheduled. Further, the documentation included that the lidocaine patch was applied on September 14, 2025 at 8:00 AM and removed on September 14, 2025 at 8:00 PM.However, there was a patch that was still present on the resident's left lower leg that was removed by staff #89 only during the medication administration observation on September 15, 2025 at 7:38 AM. Regarding Sertraline HCl tablet 100 mg:A physician order dated September 4, 2025 revealed an order for Sertraline HCl (Hydrochloride) tablet 100 mg give one tablet by mouth one time a day for sad statements related to depression.The order for Sertraline was transcribed onto the MAR for September 2025.There was no evidence found in the clinical record that the order for Sertraline 100 mg was changed since September 4, 2025.Review of the documentation in the MAR revealed that Sertraline 100 mg was administered as ordered from September 4 through September 15, 2025.However, during the medication administration observation conducted with Staff #89 on September 15, 2025 at 7:36 AM, Staff #89 dispensed and administered one tablet of Sertraline 50 mg to Resident #24.On September 15, 2025, at 10:16 AM, an interview was conducted with Certified Medication Assistant (CMA/Staff #31) who was standing next to the medication cart. She pulled out Resident #24's new bubble pack of Sertraline HCl 100 mg and explained that the resident previously took 50 mg, but the order had been changed to 100 mg. The CMA stated the new 100 mg bubble pack must have arrived two days ago. However, she stated that she administered two 50 mg tablets to the resident the previous day because she had not seen the new 100 mg bubble pack until then.On September 16, 2025, at 10:01 AM, an interview was conducted with the Director of Nursing (DON/Staff #80) who stated that the expectation for all staff, including himself, during medication administration is to follow facility policy, review the order, and follow the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician's instructions. The DON explained that when a medication dosage is changed such as when the psychiatric provider increases the dose of a psychotropic medication, the facility policy requires a new assessment and a new consent form. He said that if the change was made during rounds, the provider was responsible for obtaining the consent; and, a new order is then placed, the pharmacy delivers the updated medication, and the new dosage is administered the following day. Regarding resident #24, the DON stated that the previous dosage for Sertraline was 50 mg, which was increased to 100 mg; and that, according to their policy, the old 50 mg medication bubble pack should be returned to the pharmacy, and a new 100 mg bubble pack should be used. He further stated that during medication administration, staff must follow the doctor's orders at all times.-Resident #64 was admitted to the facility on [DATE] with diagnoses that included Hypertension, Anxiety Disorder and Depression.The care plan dated May 25, 2023 revealed resident was on an opiate medication and was at risk for pain related to chronic pain. Intervention included to administer analgesia medications as per orders.The physician order July 19, 2025 revealed an order for Lidocaine External Patch 4% apply to ankle topically one time a day for pain. The order did not include a schedule when to apply and when to remove the patch.The order for Lidocaine patch was transcribed to be applied in AM onto the MAR for September 2025. However, it did not include a transcribed schedule on when to remove the patch. During a medication administration observation conducted with staff #89 on September 15, 2025 at 7:43 AM, staff #89 prepared the lidocaine 4% one patch (topical anesthetic) to be administered to resident #64. At 7:49 Am, staff #89 removed a patch from the resident's right ankle then placed a new Lidocaine patch on the same site.-Resident #9 was admitted to the facility on [DATE] with diagnoses of hypertension and urinary tract infection (UTI).A physician order dated August 15, 2025 revealed an order for Lidocaine External Patch 4% apply to right shoulder topically in the morning for pain. The order did not include a schedule for when to remove the patch.The lidocaine patch order was transcribed onto the MAR for September 2025. However, it did not include a transcribed schedule on when to remove the patch. On September 15, 2025 at 8:06 AM, a medication administration observation was conducted with Registered Nurse (RN/Staff #54). The RN dispensed one lidocaine patch 4% one patch and at 8:08 AM, Staff #54 removed a patch from Resident #9's right shoulder and then applied the new Lidocaine patch below the right shoulder. -Resident #86 was admitted to the facility on [DATE] with diagnoses that included Hypertension, Depression, Post Traumatic Stress Disorder (PTSD), and Morbid Obesity.The care plan dated April 15, 2025 revealed resident was on diuretic therapy related to edema. Interventions included to administer medication as ordered; observe for possible side effects every shift which may cause dizziness, postural hypotension, fatigue, and an increased risk for falls; monitor dose which may require modification in order to achieve desired effects while minimizing adverse consequences especially when multiple antihypertensives are prescribed simultaneously; when discontinuing, gradual tapering may be required to avoid adverse consequences caused by abrupt cessation; and report pertinent lab results to the provider.The provider progress notes dated June 2, 2025 revealed that the resident continued to take Lasix for edema and was complaining about legs still edematous and weeping. Per the documentation, the provider planned to consult a lymphedema clinic and increase the Lasix (diuretic and brand name for Furosemide) to 20 mg twice a day.The physician order summary revealed an order for Furosemide (diuretic) tablet 20 mg give 1 tablet by mouth two times a day related to edema (order date of May 28, 2025) with no scheduled times for administration.Review of the MAR for September 2025 revealed a transcribed order for Furosemide tablet 20 mg give 1 tablet by mouth two times a day related to edema scheduled to be administered at 8:00 AM and 12:00 PM (approximately 4 hours apart).However, there was no evidence found in the clinical record of any physician order that indicated Furosemide were to be administered at 8:00 AM and 12:00 PM (approximately 4 hours apart). Continued review of the MAR for September 2025 revealed that Furosemide was administered on September 15, 2025 at 8:00 AM.On September 15, 2025 at 11:26 AM, a medication administration observation was conducted with LPN/Staff #47 who dispensed Furosemide 20 mg and administered the medication to the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident at 11:28 AM (approximately 3 1/2 hours from the last administration)An interview was conducted on September 15, 2025 at 2:41 PM with a Registered Nurse (RN/ Staff #54) who when a diuretic such as Furosemide is ordered once daily, it is usually given around 7:00 or 8:00 AM; and, if it is ordered for twice daily, it is usually administered at 8:00 AM and 4:00 PM to avoid the resident being up all night urinating. The RN said that giving Furosemide at 8:00 AM and again at 12:00 PM could cause excessive urination and increase the risk of dehydration. Further, she stated she was not aware of any residents receiving Furosemide on an 8:00 AM and 12:00 PM schedule. On September 16, 2025, at 8:40 AM, a phone interview was conducted with the provider (Staff #450) who stated that lidocaine patches are ordered either once daily or as needed, and the pharmacy label includes instructions for application. The provider said that there was no specific order to remove the patch because it was considered common sense that it should not be left on for days. Further, the provider said that the expectation was that staff would remove it appropriately; and that, the facility follows standard protocol for lidocaine patch use as directed by the pharmacy. Regarding Furosemide, the provider stated that the standard of practice for a twice daily order of Furosemide was that the drug is administered at 8:00 AM and evening, i.e., one dose in the morning and the another dose in the evening. Further, the provider said that he does not advice Furosemide to be taken in the morning and at noon.A phone interview was conducted with the pharmacist (Staff #480) on September 16, 2025 at 9:20 AM. The pharmacist stated that the lidocaine 4% patch was a facility/house stock so the pharmacy do not deliver Lidocaine 4% patch to the facility. Regarding Furosemide, the pharmacist stated that the administration times for Furosemide was dependent on the facility. She stated that the pharmacy does not enter administration times unless provider specifies this in their order. The pharmacist said that Furosemide was usually administered 6 to 8 hours apart and not less than 6 to 8 hours; and that, each resident reaction to furosemide was different such as it might cause a blood pressure drop, dizziness or frequent urination. Further, the pharmacist said that if administered too often or continuously, it can cause dehydration.An interview was conducted on September 16, 2025 at 9:41 AM with Staff #47 and present during the interview was Staff #503 at the nursing station. Staff #47 stated that regarding diuretic medication, she stated that a diuretic medication draws water out of the body from the kidneys, the diuretics mostly given at the facility is Lasix/furosemide. Staff #47 stated that she administers the medication when doctor schedules it, sometimes in the morning or sometimes in the afternoon, and usually the second dose is given at 4:00 PM. Staff #47 stated that if one dose is given in the morning, the second dose is given at 4:00 PM so resident can go to sleep and not urinate all night. Staff #47 stated that the Furosemide order for Resident #86 was furosemide 20 mg twice a day which is scheduled to be administered at 8:00 AM and at noon time. Staff #47 stated that the administration times, 8:00 AM and at noon time, for the Furosemide was how the provider/Staff #600 had it scheduled and was based on the doctor's order. Staff #47 suggested that the surveyor should ask the resident why it was ordered that way. In addition, Staff #47 stated that the resident might have asked the doctor to order it that way. However, Staff #47 stated that if she sees an order for Furosemide twice a day scheduled for 8:00 AM and at 12:00 PM, she would question the order. Staff #47 stated that she has been giving the Furosemide at 8:00 AM and at 12:00 PM to the resident for quit sometimes because the order was written in May 2025. Staff #47 stated that the excuse the doctor gave to her last time was the resident want that scheduled at 8:00 and at 12:00 PM.On September 16, 2025, at 9:41 AM, an interview was conducted with an LPN orientee (Staff #503) and an LPN (Staff #47). Staff #47 stated that diuretics like Lasix (Furosemide) remove excess water from the body through the kidneys. She stated that she administers the medication according to the physician's schedule which is sometimes in the morning or afternoon. Staff #47 said that if Lasix was ordered for twice daily, the second dose was usually given at 4:00 PM; and, this timing allows residents to sleep through the night without frequent urination. Staff #47 stated that Resident #86 had a physician's order for Furosemide 20 mg twice a day, scheduled at 8:00 AM and 12:00 PM. She said that this schedule was based on the provider's instructions and it might have been requested by the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident. Staff #47 said that although she would typically question a twice-daily Furosemide order set for 8:00 AM and 12:00 PM, she had been administering it that way to Resident #86 since the order was written in May 2025. She also stated the provider had previously informed her that the resident preferred the medication be given at those times.In an interview conducted on September 16, 2025, at 10:01 AM, the Director of Nursing (DON/Staff #80) who stated that the expectation during medication administration for all staff, including himself, was to follow facility policy, review the order, and follow the physician's instructions. Regarding Furosemide, the DON stated that Furosemide is given as ordered by the physician. The DON said that if Furosemide was ordered for twice a day, without specific times, the expectation was for staff to follow the doctor's order; and that, the schedule for administration for medications was set in their electronic record. The DON stated that if Furosemide was ordered for twice a day, it will be given in the morning and late afternoon between 3:00 PM and 6:00 PM to facilitate restful sleep. However, he stated that his nursing judgement was not the policy. The DON stated that the expectation was for staff to follow their policy and the doctor's order to give furosemide twice a day; and in the case of Resident #86, to give the second dose of Furosemide 4 hours later. Regarding the lidocaine patch, the DON said that staff were expected to follow the doctor's order; and, failure to do so could result in the resident not receiving a needed medication. He stated that the lidocaine patch is a topical pain reliever applied by either a nurse or a Certified Medication Assistant (CMA) to the area specified in the physician's order; and that, if the physician orders removal of the patch, staff are expected to follow that order. However, the DON said that if no removal instructions were provided, the nurse may use their clinical judgment or follow the manufacturer's guidelines.During an observation at the nurses' station conducted with the DON on September 16, 2025 at 10:23 AM, the DON pulled out an unopened lidocaine patch in its original package from the medication cart. On the front side of the 4% Lidocaine Patch Pain Relief package revealed the following written information:For Single-UseEasy to Apply and RemoveStay-Put Flexible PatchNo-Mess ApplicationLasts Up to 12 HoursAnd, on the back side of the 4% Lidocaine Patch package, the direction revealed the following information:Apply sticky side of patch to affected areaUse one patch for up to 12 hoursDiscard patch after single useIn a later interview with the DON conducted on September 16, 2025 at 1:03 PM, the DON sated that the Furosemide order for Resident #86 was entered by the provider and all orders for resident #86 were reviewed by their pharmacy. The DON provided a copy of a progress note dated June 2, 2025 from the clinical record of Resident #86 and stated that the provider will increase Resident's Furosemide to 20 mg twice a day; however, the documentation of the order in the progress note did not indicate a specific instruction for Furosemide to be administered at 8:00 AM and at 12:00 PM. The DON stated that he clarified with the provider today, September 16, 2025 the Furosemide order and documented this in the clinical record. According to [NAME] Nursing Drug Handbook, Furosemide is used for the treatment associated with heart failure and renal/hepatic disease; and acute pulmonary edema. The pharmacokinetics (study of how the body interacts with administered substances for the entire duration of exposure) of the drug when taken by mouth are: the onset of the drug when taken orally is 30 to 60 minutes, the drug peaks in 1 to 2 hours, and the duration is 6 to 8 hours. It also included a half-life of 30-90 minutes. Black Box Alert included that large doses can lead to profound diuresis with water and electrolyte depletion. Expected side effects included increased urinary frequency/volume, electrolyte imbalance, dizziness, light-headedness, blurred vision, diaphoresis and blurred vision.The medlineplus.gov website last revised on June 15, 2021 included that nonprescription lidocaine transdermal comes as a 4% patch to apply to the skin. It is applied up to 3 times daily and for no more than 8 hours per application. Use nonprescription lidocaine patches exactly as directed. Do not use more or less of it or use it more often or for a longer period of time than directed by the package instructions. The doctor will tell you how many lidocaine patches or topical systems you may use at one time and the length of time you may wear the patches. Applying too many patches or topical systems or leaving them on for too long may cause serious side effects.Review of facility policy on Medication and Treatment Orders, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Lakeside	3401 North Lockwood Drive Lakeside, AZ 85929

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	effective January 1, 2024 revealed that orders for medications and treatments will be consistent with principles of safe and effective order writing. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribed such medications in this state. Drug and biological orders must be recorded on the physician's order sheet in the resident's chart. Such orders are reviewed by the consultant pharmacist on a monthly basis.Review of facility policy titled, F014-Medications: Medication Administration Schedule, effective January 1, 2024 revealed medication are administered according to established scheduled and following routine schedule. For ordered times of BID (two times a day), policy did not indicate what time in a.m. and in p.m. should the medication be given. Per the policy, scheduled medications are administered within one (1) hour of their prescribed time, unless otherwise specified. A physician's order for specific times supersedes any routine schedule. Residents may request alternate medication schedules. Such times must be documented on the resident's medication administration record and care plan.

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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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on documentation, staff interviews, and facility policies the facility failed to ensure that four staff members (#21, #58, #1, & 55) received Disaster training. The deficient practice could result in staff not being familiar with the procedures to follow in the event of an emergency and/or disaster.Findings include:On September 15, 2025 at 9:11 a.m., a written request for personnel files which included staffs #21, #58, #24, #16, #1, & 55) was submitted specifically asking for proof of Disaster training. -Regarding Staff #21Review of the personnel record for a Registered Nurse (RN/staff #21) revealed a hire date of August 1, 2024. Additionally, the personnel file revealed a signed job description dated August 4, 2024 that outlined tasks and responsibilities which stated that staff will participate in all required meetings, trainings and events. The file also included a New Employee Orientation Acknowledgement signed August 4, 2025. However, it did not indicate what training were covered under this orientation. Further review of the personnel file provided by the facility did not reveal any evidence that staff #21 completed Disaster training. Review of the Inservice training log/binder conducted on September 15, 2025 at 4:03 p.m. did not reveal any evidence that staff #21 completed Disaster training. Furthermore, during a sit down with Human Resource (HR/staff #70) conducted on September 16, 2025 at 9:47 a.m., staff #70 along with the surveyor verified on the training system that Disaster training was not assigned or completed by staff #21. HR noted that he would have to call the training system resource to add courses. However, an email sent by the facility after the survey exit, received September 17, 2025 at 2:09 p.m. noted that all staff sampled had completed training. An attachment marked Clinical Staff Annual Education with a handwritten start date of June 15, 2025 and finished date of July 15, 2025 indicated that Disaster was a topic covered. The training included a typed roster with a list of the staff and a training complete section. The roster included staff #21's typed name and on the training complete section a handwritten check mark was annotated. There was no clear indication of when staff #21 and the other staff on the roster actually completed the training. -Regarding Staff #58Review of the personnel record for a Licensed Practical Nurse (LPN/staff #58) revealed a hire date of September 20, 2016. The personnel file provided by the facility did not reveal any evidence that staff #58 completed Disaster training. Additionally, the personnel file revealed a signed job description dated September 20, 2016 that outlined tasks and responsibilities which stated that staff will participate in all required meetings, trainings and events. An interview with Human Resource (HR/staff #70) conducted on September 15, 2025 at 2:04 p.m. Staff #70 stated that the training system itself is the one that assigns the courses. However, based on the personnel records that was reviewed together with the surveyor, he would need to find out why courses are not being assigned. According to HR the expectation is that assigned training is completed a month from when it is assigned. Review of the Inservice training log/binder conducted on September 15, 2025 at 4:03 p.m. did not reveal any evidence that staff #58 completed Disaster training. During a sit down with HR to conduct personnel record review specific to training, conducted on September 16, 2025 at 9:47 a.m., staff #70 stated that review of their training system revealed that the Disaster training was an assigned training indicated in the system for staff #58. However, it has not been completed by the member. However, an email sent by the facility after the survey exit, received September 17, 2025 at 2:09 p.m. noted that all staff sampled had completed training. An attachment marked Clinical Staff Annual Education with a handwritten start date of June 15, 2025 and finished date of July 15, 2025 indicated that Elder Justice Act was among the topics covered. The training included a typed roster with a list of the staff and a training complete section. The roster included staff #58's typed name and on the training complete section a handwritten check mark was annotated. There was no clear indication of when staff #58 and the other staff on the roster actually completed the training-Regarding Staff #1Review of the personnel record for a Certified Nursing Assistant (CNA/staff #1) revealed a hire date of February 28, 2025. The file also included a New (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employee Orientation Acknowledgement signed February 28,2025. However, it did not indicate what training were covered under this orientation. Additionally, the personnel file revealed a signed job description signed on April 4, 2025 that outlined roles and responsibilities which stated that staff will participate in all required meetings, trainings and events. Further review of the personnel file provided by the facility did not reveal any evidence that staff #1 completed Disaster training. During the review of the training system with staff #70 for staff #1's training completion conducted on September 15, 2025 at 2:04 p.m., he noted that there is no documentation of Disaster training on either the training system or orientation. An interview with Human Resource (HR/staff #70) conducted on September 15, 2025 at 2:04 p.m. Staff #70 stated that the training system itself is the one that assigns the courses. However, based on the personnel records that was reviewed together with the surveyor, he would need to find out why courses are not being assigned. According to HR the expectation is that assigned training is completed a month from when it is assigned. Staff #70 recommended to check Inservice training log/binder to determine if staff # 1 completed Disaster training since it was not on the training system or the orientation training. Review of the Inservice training log/binder conducted on September 15, 2025 at 4:03 p.m. did not reveal any evidence that staff #1 completed Disaster training. Furthermore, during a sit down with Human Resource (HR/staff #70) conducted on September 16, 2025 at 9:47 a.m., staff #70 along with the surveyor verified on the training system that staff #1 had no documented Disaster training. HR noted that he would have to call the training system resource to add courses. Review of the email sent by the facility after the survey exit, received September 17, 2025 at 2:09 p.m. noted that all staff sampled had completed training. The following attachments were reviewed:- In-Service roster dated September 26, 2024 = did not include staff #1's name/was prior to hire date- In-Service roster dated May 20, 2025 = did not include staff #1's name- Clinical Staff Annual Education roster (June 15, 2025 - July 15, 2025) = typed name and handwritten check mark was annotated with no clear indication of when staff member actually completed the training -Regarding Staff #55Review of the staff list for a Licensed Practical Nurse (LPN/staff #55) revealed a hire date of February 5, 2019. Additionally, the personnel file revealed a signed job description dated February 12, 2025 that outlined tasks and responsibilities which stated that staff will participate in all required meetings, trainings and events. The file also included a New Employee Orientation Acknowledgement signed February 12, 2025. However, it did not indicate what training were covered under this orientation. Review of the personnel file provided by the facility did not reveal any evidence that staff #55 completed Disaster training. Furthermore, during a sit down with the Human Resource (HR/staff #70) to conduct personnel record review specific to training, conducted on September 15, 2025 at 2:04 p.m., staff #70 stated that staff #55 does not have documentation on either the training system or orientation for Disaster training. HR recommended to check the Inservice binder to determine if staff #55 had completed the training. Review of the Inservice training log/binder conducted on September 15, 2025 at 4:03 p.m., did not reveal any evidence that staff #55 had completed Disaster training. Furthermore, during a follow-up sit down with Human Resource (HR/staff #70) conducted on September 16, 2025 at 9:47 a.m., staff #70 along with the surveyor verified on the training system that staff #55 had no documented Disaster training. HR noted that he would have to call the training system resource to add courses/get training loaded. However, review of the email sent by the facility after the survey exit, received September 17, 2025 at 2:09 p.m. noted that all staff sampled had completed training. The following attachments were reviewed:- In-Service roster dated September 26, 2024 = did not include staff #55's name- In-Service roster dated May 20, 2025 = did not include staff #55's name- Clinical Staff Annual Education roster (June 15, 2025 - July 15, 2025) = typed name and handwritten check mark was annotated with no clear indication of when staff member actually completed the training An interview with a Licensed Practical Nurse (LPN/staff #43) was conducted on September 16, 2025 at 5:18 p.m. Staff #43 stated that staff members are provider training via monthly in-service and yearly computer-based training. According to the LPN training is important for topics such as Disaster so that staff would know what to do in that situation, how to take care of the (continued on next page)

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	035277	A. Building B. Wing	11/19/2025

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident, and know how to act/think in that situation. The impact of not getting the appropriate training is that staff would not know what to do if a situation arises. During an interview with a Certified Nursing Assistant (CNA/staff #60) conducted on September 17, 2025 at approximately 8:30 a.m., staff #60 noted being a relatively new employee at the facility. According to the CNA, although on-the-job training was provided, no other training had been provided. Additionally, staff #60 was told that there would be a series of online training that would need to be completed within 2-months. Staff #60 said that training is important for everyone's safety. The CNA noted that if staff is not provided appropriate training then they would not know how to react and would have to rely on common sense. An interview with the Director of Nursing (DON/staff #80) was conducted on September 17, 2025 at 8:34 p.m. Staff #80 stated that his expectation is that staff follow the facility policy with regards to training. This means completing the onboarding process for general orientation which covers the general education to start the job and do education periodically throughout the year. According to the DON it is important to have Disaster training in order for staff to be trained on how to evacuate/respond in the situation and be prepared to protect the residents. Staff #80 said that not having training could lead to a knowledge deficit which could lead to delayed responses and impact care. The facility policy titled Staff Development Program version 0123 stated that all personnel must participate in initial orientation and regularly scheduled in-service training classes. The policy noted that Emergency Preparedness was a state agency mandatory topic. Review of the Facility Assessment updated September 15, 2025 indicated that the facility's staff/training/education and competencies included Fire, Disaster, Emergency Preparedness training. According to the facility assessment competencies are started during orientation and had to be completed during the first few weeks of hire and then annually.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on documentation, staff interviews, and facility policies the facility failed to ensure that two staff members (#21 and #58) are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents. The deficient practice could result in staff not being familiar with residents' rights. Findings include:On September 15, 2025 at 9:11 a.m., a written request for personnel files which included staffs #21 and #58 was submitted specifically asking for proof of training for Resident Rights. -Regarding Staff #21Review of the personnel record for a Registered Nurse (RN/staff #21) revealed a hire date of August 1, 2024. Additionally, the personnel file revealed a signed job description dated August 4, 2024 that outlined tasks and responsibilities which stated that staff will participate in all required meetings, trainings and events. However, review of the personnel file provided by the facility did not reveal any evidence that staff #21 completed Resident Rights training. Review of the Inservice training log/binder conducted on September 15, 2025 at 4:03 p.m. did not reveal any evidence that staff #21 completed Resident Rights training. Furthermore, during a sit down with Human Resource (HR/staff #70) to conduct personnel record review specific to training, conducted on September 16, 2025 at 9:47 a.m., staff #70 stated that review of their training system revealed that the Resident Rights training was not assigned and have not been completed by staff #21. HR noted that he would have to call the training system resource to add courses/loaded. However, an email sent by the facility after the survey exit, received September 17, 2025 at 2:09 p.m. noted that all 10 staff sampled had completed training. An attachment marked Clinical Staff Annual Education with a handwritten start date of June 15, 2025 and finished date of July 15, 2025 indicated that Resident Rights was one of the topics covered. The training included a typed roster with a list of the staff and a training complete section. The roster was included staff #21's typed name and on the training complete section a handwritten check mark was annotated. There was no clear indication of when staff #21 and the other staff on the roster actually completed the training. -Regarding Staff #58Review of the personnel record for a Licensed Practical Nurse (LPN/staff #58) revealed a hire date of September 20, 2016. A Resident's Rights Summary listing the resident's rights in long-term care facilities was signed by staff #58 on September 20, 2016. However, there was no evidence that staff #58 had current Resident Rights training. Additionally, the personnel file revealed a signed job description dated September 20, 2016 that outlined tasks and responsibilities which stated that staff will participate in all required meetings, trainings and events. An interview with Human Resource (HR/staff #70) conducted on September 15, 2025 at 2:04 p.m. Staff #70 stated that the training system itself is the one that assigns the courses. However, based on the personnel records that was reviewed together with the surveyor, he would need to find out why courses are not being assigned. According to HR the expectation is that assigned training is completed a month from when it is assigned. Review of the Inservice training log/binder conducted on September 15, 2025 at 4:03 p.m. did not reveal any evidence that staff #58 completed Resident Rights training. During a sit down with HR to conduct personnel record review specific to training, conducted on September 16, 2025 at 9:47 a.m., staff #70 stated that review of their training system revealed that the Resident Rights training was assigned but not completed by staff #58. The HR noted that the training system point of contact has to be called to add courses due to the discovery from yesterday's sit down with the survey team in which required courses were not assigned/loaded standardized for all staff. An interview with a Licensed Practical Nurse (LPN/staff #43) was conducted on September 16, 2025 at 5:18 p.m. Staff #43 stated that staff members are provider training via monthly in-service and yearly computer-based training. According to the LPN training is important for topics such as Resident Rights so that staff can determine if there is something going on that should not be happening. The impact of not getting the appropriate training is that staff would not know what to do if a situation arises. During an interview with a Certified Nursing Assistant (CNA/staff #60) conducted on September 17, 2025 at (continued on next page)

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	approximately 8:30 a.m., staff #60 noted being a relatively new employee at the facility. According to the CNA, although on-the-job training was provided, training on Resident Rights was not provided. Additionally, staff #60 was told that there would be a series of online training that would need to be completed within 2-months. The CNA indicated starting some Resident Rights training online. Staff #60 said that training is important for everyone's safety. The CNA noted that if staff is not provided appropriate training then they would not know how to react and would have to rely on common sense. An interview with the Director of Nursing (DON/staff #80) was conducted on September 17, 2025 at 8:34 p.m. Staff #80 stated that his expectation is that staff follow the facility policy with regards to training. This means completing the onboarding process for general orientation which covers the general education to start the job and do education periodically throughout the year. According to the DON it is important to have Resident Rights training in order for staff to be educated on residents' rights and protect the residents. Staff #80 said that not having training could lead to a knowledge deficit which could lead to delayed responses and impact care. However, an email sent by the facility after the survey exit, received September 17, 2025 at 2:09 p.m. noted that all 10 staff sampled had completed training. An attachment marked Clinical Staff Annual Education with a handwritten start date of June 15, 2025 and finished date of July 15, 2025 indicated that Resident Rights was one of the topics covered. The training included a typed roster with a list of the staff and a training complete section. The roster was included staff #58's typed name and on the training complete section a handwritten check mark was annotated. There was no clear indication of when staff #58 and the other staff on the roster actually completed the training. The facility policy titled Staff Development Program version 0123 stated that all personnel must participate in initial orientation and regularly scheduled in-service training classes. The policy noted that Resident's Rights was a state agency mandatory topic. Review of the Facility Assessment updated September 15, 2025 indicated that the facility's staff/training/education and competencies included Resident Rights and facility responsibilities to properly care for its residents. According to the facility assessment competencies are started during orientation and had to be completed during the first few weeks of hire and then annually.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on documentation, staff interviews, and facility policies the facility failed to ensure that one staff member (#21) was educated on abuse, and that seven staff members (#21, #58, #24, #1, #12, #55 & #11) and one nursing aide (NA) student (staff #255) received Elder Justice Act training. The deficient practice could result in staff not being familiar with the detection, prevention and reporting of abuse, neglect, and exploitation of property.Findings include:On September 15, 2025 at 9:11 a.m., a written request for personnel files which included staffs #21, #58, #24, #1, #12, #55 & #11) was submitted specifically asking for proof of training for Abuse and Elder Justice Act. Additionally, a written request for personnel file for staff #255 specifically asking for proof of training for Abuse and Elder Justice Act was submitted on September 15, 2025 at 10:16 a.m. -Regarding Staff #21Review of the personnel record for a Registered Nurse (RN/staff #21) revealed a hire date of August 1, 2024. Additionally, the personnel file revealed a signed job description dated August 4, 2024 that outlined tasks and responsibilities which stated that staff will participate in all required meetings, trainings and events. The file also included a New Employee Orientation Acknowledgement signed August 4, 2025. However, it did not indicate what training were covered under this orientation. Further review of the personnel file provided by the facility did not reveal any evidence that staff #21 completed Abuse and/or Elder Justice Act training. Review of the Inservice training log/binder conducted on September 15, 2025 at 4:03 p.m. did not reveal any evidence that staff #21 completed Abuse and/or Elder Justice Act training. Furthermore, during a sit down with Human Resource (HR/staff #70) to conduct personnel record review specific to training, conducted on September 16, 2025 at 9:47 a.m., staff #70 along with the surveyor verified on the training system that Abuse and Elder Justice Act training were not assigned or completed by staff #21. HR noted that he would have to call the training system resource to add courses/loaded. However, an email sent by the facility after the survey exit, received September 17, 2025 at 2:09 p.m. noted that all staff sampled had completed training. An attachment marked Clinical Staff Annual Education with a handwritten start date of June 15, 2025 and finished date of July 15, 2025 indicated that Abuse and Elder Justice Act were topics covered. The training included a typed roster with a list of the staff and a training complete section. The roster included staff #21's typed name and on the training complete section a handwritten check mark was annotated. There was no clear indication of when staff #21 and the other staff on the roster actually completed the training. -Regarding Staff #58Review of the personnel record for a Licensed Practical Nurse (LPN/staff #58) revealed a hire date of September 20, 2016. Additionally, the personnel file included a Preventing and Reporting Resident Abuse: Clinical Practices and the Elder Justice Act form signed September 20, 2016. However, there was no evidence that staff #58 had current Elder Justice Act training. Furthermore, the personnel file revealed a signed job description dated September 20, 2016 that outlined tasks and responsibilities which stated that staff will participate in all required meetings, trainings and events. An interview with Human Resource (HR/staff #70) conducted on September 15, 2025 at 2:04 p.m. Staff #70 stated that the training system itself is the one that assigns the courses. However, based on the personnel records that was reviewed together with the surveyor, he would need to find out why courses are not being assigned. According to HR the expectation is that assigned training is completed a month from when it is assigned. Review of the Inservice training log/binder conducted on September 15, 2025 at 4:03 p.m. did not reveal any evidence that staff #58 completed Elder Justice Act training. During a sit down with HR to conduct personnel record review specific to training, conducted on September 16, 2025 at 9:47 a.m., staff #70 stated that review of their training system revealed that the Elder Justice Act training was not a training indicated in the system for staff #58. The HR noted that the training system point of contact has to be called to add courses due to the discovery from yesterday's sit down with the survey team in which required courses were not assigned/loaded standardized for all staff. However, an email (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sent by the facility after the survey exit, received September 17, 2025 at 2:09 p.m. noted that all staff sampled had completed training. An attachment marked Clinical Staff Annual Education with a handwritten start date of June 15, 2025 and finished date of July 15, 2025 indicated that Elder Justice Act was among the topics covered. The training included a typed roster with a list of the staff and a training complete section. The roster included staff #58's typed name and on the training complete section a handwritten check mark was annotated. There was no clear indication of when staff #58 and the other staff on the roster actually completed the training. -Regarding Staff #24Review of the personnel record for the Activity Director (staff #24) revealed a hire date of October 18, 2024. Additionally, the personnel file revealed a signed job description dated October 18, 2024 that outlined tasks and responsibilities which stated that staff will participate in all required meetings, trainings and events. The file also included a New Employee Orientation Acknowledgement signed October 18, 2024. However, it did not indicate what training were covered under this orientation. Further review of the personnel file provided by the facility did not reveal any evidence that staff #58 completed Elder Justice Act training. An interview with Human Resource (HR/staff #70) conducted on September 15, 2025 at 2:04 p.m. Staff #70 stated that the training system itself is the one that assigns the courses. However, based on the personnel records that was reviewed together with the surveyor, he would need to find out why courses are not being assigned. According to HR the expectation is that assigned training is completed a month from when it is assigned. During the review of the training system with staff #70 for staff #24's training completion, he noted that there is no documentation of Elder Justice Act completion and said that staff #24 might have done an Inservice training. Review of the Inservice training log/binder conducted on September 15, 2025 at 4:03 p.m. did not reveal any evidence that staff #24 completed Elder Justice Act training. Furthermore, during a sit down with Human Resource (HR/staff #70) conducted on September 16, 2025 at 9:47 a.m., staff #70 along with the surveyor verified on the training system that staff #24 had no documented Elder Justice Act training. HR noted that he would have to call the training system resource to add courses/loaded. Review of the email sent by the facility after the survey exit, received September 17, 2025 at 2:09 p.m. noted that all staff sampled had completed training. The following attachments were reviewed:-In-Service roster dated September 26, 2024 = did not include staff #24's name/was prior to hire date- In-Service roster dated May 20, 2025 = training topics did not include Elder Justice Act- Clinical Staff Annual Education roster (June 15, 2025 - July 15, 2025) = did not include staff #24's name -Regarding Staff #1Review of the personnel record for a Certified Nursing Assistant (staff #1) revealed a hire date of February 28, 2025. The file also included a New Employee Orientation Acknowledgement signed February 28,2025. However, it did not indicate what training were covered under this orientation. Additionally, the personnel file revealed a signed job description signed on April 4, 2025 that outlined roles and responsibilities which stated that staff will participate in all required meetings, trainings and events. Further review of the personnel file provided by the facility did not reveal any evidence that staff #1 completed Elder Justice Act training. During the review of the training system with staff #70 for staff #1's training completion conducted on September 15, 2025 at 2:04 p.m., he noted that there is no documentation of Elder Justice Act on either the training system or orientation. An interview with Human Resource (HR/staff #70) conducted on September 15, 2025 at 2:04 p.m. Staff #70 stated that the training system itself is the one that assigns the courses. However, based on the personnel records that was reviewed together with the surveyor, he would need to find out why courses are not being assigned. According to HR the expectation is that assigned training is completed a month from when it is assigned. Staff #70 recommended to check Inservice training log/binder to determine if staff # 1 completed Elder Justice Act since it was not on the training system or the orientation training. Review of the Inservice training log/binder conducted on September 15, 2025 at 4:03 p.m. did not reveal any evidence that staff #1 completed Elder Justice Act training. Furthermore, during a sit down with Human Resource (HR/staff #70) to conduct personnel record review specific to training, conducted on September 16, 2025 at 9:47 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Haven of Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 North Lockwood Drive Lakeside, AZ 85929	

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a.m., staff #70 along with the surveyor verified on the training system that staff #1 had no documented Elder Justice Act training. HR noted that he would have to call the training system resource to add courses/loaded. Review of the email sent by the facility after the survey exit, received September 17, 2025 at 2:09 p.m. noted that all staff sampled had completed training. The following attachments were reviewed:- In-Service roster dated September 26, 2024 = did not include staff #1's name/was prior to hire date- In-Service roster dated May 20, 2025 = training topics did not include Elder Justice Act- Clinical Staff Annual Education roster (June 15, 2025 - July 15, 2025) = typed name and handwritten check mark was annotated with no clear indication of when staff member actually completed the training -Regarding Staff #12Review of the personnel record for a Certified Nursing Assistant (CNA/staff #12) revealed a hire date of June 19, 2025. Additionally, the personnel file revealed a signed job description dated June 19, 2025 that outlined role and responsibilities which stated that staff will participate in all required meetings, trainings and events. The file also included a New Employee Orientation Acknowledgement signed June 19, 2025. However, it did not indicate what training were covered under this orientation. During a sit down with Human Resource (HR/staff #70) to conduct personnel record review specific t training, conducted on September 15, 2025 at 2:04 p.m., staff #70 stated that review of their training system revealed that staff #12 does not have Elder Justice Act on either the orientation or training system. HR recommended to check the Inservice log to determine if staff #12 had completed the training. Review of the Inservice training log/binder conducted o September 15, 2025 at 4:03 p.m. did not reveal any evidence that staff #12 completed Elder Justice Act training. Furthermore, during a follow-up sit down with Human Resource (HR/staff #70) conducted on September 16, 2025 at 9:47 a.m., staff #70 along with the surveyor verified on the training system that staff #12 had no documented Elder Justice Act training. HR noted that he would have to call the training system resource to add courses/loaded. Review of the email sent by the facility after the survey exit, received September 17, 2025 at 2:09 p.m. noted that all staff sampled had completed training. The following attachments were reviewed:- In-Service roster dated September 26, 2024 = did not include staff #12's name/was prior to hire date- In-Service roster dated May 20, 2025 = did not include staff #12's name/was prior to hire date- Clinical Staff Annual Education roster (June 15, 2025 - July 15, 2025) = typed name and handwritten check mark was annotated with no clear indication of when staff member actually completed the training -Regarding Staff #55Review of the staff list for a Licensed Practical Nurse (LPN/staff #55) revealed a hire date of February 5, 2019. Additionally, the personnel file revealed a signed job description dated February 12, 2025 that outlined tasks and responsibilities which stated that staff will participate in all required meetings, trainings and events. The file also included a New Employee Orientation Acknowledgement signed February 12, 2025. However, it did not indicate what training were covered under this orientation. Review of the personnel file provided by the facility did not reveal any evidence that staff #55 completed Elder Justice Act training. Furthermore, during a sit down with the Human Resource (HR/staff #70) to conduct personnel record review specific to training, conducted on September 15, 2025 at 2:04 p.m., staff #70 stated that staff #55 does not have documented training on either the training system or orientation for Elder Justice Act. HR recommended to check the Inservice binder to determine if staff #55 had completed the training. Review of the Inservice training log/binder conducted on September 15, 2025 at 4:03 p.m., did not reveal any evidence that staff #55 had completed Elder Justice Act training. Furthermore, during a follow-up sit down with Human Resource (HR/staff #70) conducted on September 16, 2025 at 9:47 a.m., staff #70 along with the surveyor verified on the training system that staff #55 had no documented Elder Justice Act training. HR noted that he would have to call the training system resource to add courses/ get training loaded. However, review of the email sent by the facility after the survey exit, received September 17, 2025 at 2:09 p.m. noted that all staff sampled had completed training. The following attachments were reviewed:- In-Service roster dated September 26, 2024 = did not include staff #55's name- In-Service roster dated May 20, 2025 = training topics does not include (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Elder Justice Act- Clinical Staff Annual Education roster (June 15, 2025 - July 15, 2025) = typed name and handwritten check mark was annotated with no clear indication of when staff member actually completed the training -Regarding Staff #11Review of the personnel record for a Registered Nurse (RN/staff #11) revealed a hire date of February 17, 2025. Additionally, the personnel file revealed a signed job description dated February 18, 2025 that outlined tasks and responsibilities which stated that staff will participate in all required meetings, trainings and events. The file also included a New Employee Orientation Acknowledgement signed February 18, 2025. However, it did not indicate what training were covered under this orientation. Review of the personnel file provided by the facility did not reveal any evidence that staff #11 completed Elder Justice Act training. Furthermore, during a sit down with the Human Resource (HR/staff #70) to conduct personnel record review specific to training, conducted on September 15, 2025 at 2:04 p.m., staff #70 stated that staff #11 does not have documented training on either the training system or orientation for Elder Justice Act. HR recommended to check the Inservice binder to determine if staff #11 had completed the training. Review of the Inservice training log/binder conducted on September 15, 2025 at 4:03 p.m., did not reveal any evidence that staff #11 had completed Elder Justice Act training. During a follow-up sit down with Human Resource (HR/staff #70) conducted on September 16, 2025 at 9:47 a.m., staff #70 along with the surveyor verified on the training system that staff #11 had no documented Elder Justice Act training. HR noted that he would have to call the training system resource to add courses/ get training loaded. However, review of the email sent by the facility after the survey exit, received September 17, 2025 at 2:09 p.m. noted that all staff sampled had completed training. The following attachments were reviewed:- In-Service roster dated September 26, 2024 = did not include staff #11's name/was prior to hire date- In-Service roster dated May 20, 2025 = training topics does not include Elder Justice Act- Clinical Staff Annual Education roster (June 15, 2025 - July 15, 2025) = typed name and handwritten check mark was annotated with no clear indication of when staff member actually completed the training -Regarding Staff #255Review of the Nursing Assistant Class roster for September 2025 revealed a class start date of August 25, 2025. The roster listed staff #255 as one of the participants of the program. A written request for personnel record for Nursing Assistant student (staff #255) was submitted to the facility on September 15, 2025 at 10:16 a.m. The request included proof of completion for Elder Justice Act Training. An email response was received from the facility on September 15, 2025 at 10:50 a.m. which stated that the staff #255 was not an employee but a participant in the Certified Nursing Assistant (CNA) class. The email noted that due to staff #255's status, all they have on file is a Tuberculosis test. Furthermore, per the email the items listed as part of the personnel record request were not required to obtain for non-employees participating in the free CNA class. Review of the Inservice training log/binder conducted on September 15, 2025 at 4:03 p.m. did not reveal any evidence that staff #21 completed Resident Rights training. Additionally, attachments from the email received from the facility on September 15, 2025 at 4:18 p.m. did not include proof of fingerprint clearance card (FPCC) for staff #255. Review of an undated Application for Employment |Recruiter Added FREE CNA Training Program Lakeside revealed that staff #255 submitted the form for consideration for CNA training. The Consent/Acknowledgement section of the form indicated that staff #255 acknowledge and certify:-Equal Employment Opportunity-Employment-At-Will Although, the facility provided a sheet that outlined the General Orientation Topics, review of the email attachments from the facility dated September 15, 2025 did not reveal any documentation of training completion for Elder Justice Act. An interview with a Licensed Practical Nurse (LPN/staff #43) was conducted on September 16, 2025 at 5:18 p.m. Staff #43 stated that staff members are provider training via monthly in-service and yearly computer-based training. According to the LPN training is important for topics such as Abuse so that staff can determine if there is something going on that should not be happening. The impact of not getting the appropriate training is that staff would not know what to do if a situation arises. During an interview with a Certified Nursing Assistant (CNA/staff #60) conducted on September 17, 2025 at (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	approximately 8:30 a.m., staff #60 noted being a relatively new employee at the facility. According to the CNA, although on-the-job training was provided, training on Abuse and Elder Justice Act were not provided. Additionally, staff #60 was told that there would be a series of online training that would need to be completed within 2-months. Staff #60 said that training is important for everyone's safety. The CNA noted that if staff is not provided appropriate training then they would not know how to react and would have to rely on common sense. An interview with the Director of Nursing (DON/staff #80) was conducted on September 17, 2025 at 8:34 p.m. Staff #80 stated that his expectation is that staff follow the facility policy with regards to training. This means completing the onboarding process for general orientation which covers the general education to start the job and do education periodically throughout the year. According to the DON it is important to have Abuse training in order for staff to be trained on how to identify and report appropriately so allegations can be investigated by the facility. Additionally, it is important for staff to be trained on Elder Justice Act so know the resident's rights and how to treat them. Staff #80 said that not having training could lead to a knowledge deficit which could lead to delayed responses and impact care. The facility policy titled Staff Development Program version 0123 stated that all personnel must participate in initial orientation and regularly scheduled in-service training classes. The policy noted that Abuse was a state agency mandatory topic. The policy did not mention anything regarding Elder Justice Act training. Review of the Facility Assessment updated September 15, 2025 indicated that the facility's staff/training/education and competencies included Abuse, Neglect, and Exploitation. According to the facility assessment competencies are started during orientation and had to be completed during the first few weeks of hire and then annually. There was no specific mention regarding Elder Justice Act training. The facility policy titled Abuse Policy version 0622 indicated that all employees receive education on the Elder Justice Act as well as contact and reporting information. The policy noted that education will be provided regarding abuse prevention, recognition, and reporting procedures during new hire orientation, annual in-service, and as needed.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure that the advance directive was consistent and correct for one Resident.(#7)Number of residents sampled: 20Number of residents cited: 1 Based on clinical record review, staff interviews, and facility policy and procedure, the facility failed to ensure that the advance directives were consistent throughout one (#7) of twenty sampled resident's clinical records. The deficient practice could result in residents receiving services that are not in accordance with their wishes. Findings include: Resident #7 was admitted to the facility on [DATE],.2025 with diagnoses that included Chronic Obstructive Pulmonary Disorder, Atrial Fibrillation and Vascular Dementia. The resident was admitted to Hospice on August 18,2025. A Prehospital Medical Care directive signed by the resident's representative on August 18,2025 provided by the Hospice, revealed the resident chose the code status of DNR. (Do not resuscitate). The advance directive form signed by the resident on August 22, 2025 found in the clinical record, revealed that no selection was made in relation to the choices of Full Code or DNR code status. No selection was made on the signed form. There was no evidence that the residents code status was reflected in the care plan or the physician's orders for resident #7.An interview was conducted on September 15,2025 at 2:35 p.m. with the Clinical Resource Staff # 888 She stated that the Advance Directive on file for resident #7was not adequate as the resident's choice was unclear, as no choice was clearly selected on the form in the clinical record of the resident. She further stated that this may cause confusion as to the residents wishes.An interview was conducted on September 15, 2025 at 2:42 p.m. with Registered Nurse/ staff # 54. She stated that during an emergent code situation, to determine the residents code status, staff would look at the banner on the resident's electronic chart and the then check the hard chart book that is kept at the nurse's station. She stated that in the case of resident # 7, the banner indicated that the resident was a DNR and the paperwork in the hard chart indicated that the resident had not selected a code status on the signed form Staff #54 stated that by default, this lack of a choice on the signed document made the resident a full code. Looking further into the hard chart book, a signed DNR can be found however, the RN stated that the lack of consistency throughout the resident's clinical record could lead to confusion on the part of the staff and therefore, the resident's wishes may not be followed. The facility policy Advance Directives (4/2013) revealed that changes or revocations of the residents advance directive must be in writing to the administrator and changes should be reflected in the resident's MDS (minimum data set) and care plan. It further revealed that the Director of Nursing or designee would notify the Attending Physician of the advance directives of the resident so that appropriate orders can be reflected in the resident's medical record and plan of care.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **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 resident (#14) was referred for Level II Pre-admission Screening and Resident Review (PASRR). The deficient practice could result in residents not receiving appropriate services to meet their needs.Number of residents sampled: 20Number of residents cited: 1Findings include:Resident #14 was initially admitted on [DATE] and was readmitted to the facility on [DATE] with a diagnosis that included myocardial infarction, depression, anxiety disorder, bipolar disorder, and schizoaffective disorder.A review of care plan dated January 3, 2024 revealed resident use antipsychotic and antidepressant medications related to schizoaffective disorder. Interventions included to administer medications as ordered, monitor side effects of the antipsychotic medication and report side effects and adverse reactions of medication to provider; and consult with pharmacy and provider to consider gradual dosage reduction (GDR) when clinically appropriate.A care plan dated January 15, 2024 revealed resident had a psychosocial well-being problem potential related to anxiety, depression, psychosis, substance abuse, schizoaffective disorder, and bipolar disorder. The interventions included to allow resident to answer questions and to verbalize feelings, perceptions, and fears; and to initiate referrals as needed or increase social relationships.Review of the Level I PASRR (Pre-admission Screening and Resident Review) document dated March 8, 2024 revealed resident did not have Serious Mental Illness (SMI) such as Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Major Depression or Paranoid Disorder; and, resident had anxiety disorder and depression as mental disorders. Further, the documentation included that no referral necessary for any Level II.A review of Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15.0 indicating the resident was cognitively intact. Active diagnoses included anxiety disorder, depression and bipolar disorder. The assessment also included that the resident was on antianxiety and antidepressant medications.Despite documentation that the resident had diagnoses of anxiety, depression, psychosis, schizoaffective disorder, and bipolar disorder and a care plan intervention initiate referrals as needed, there was no evidence found that a referral for level two PASRR was completed for resident #14.A provider progress notes dated May 19, 2025 revealed assessments which included psychotic disorder with hallucinations, active auditory hallucinations, Bipolar disorder, depression, anxiety disorder, and insomnia.The MDs assessment dated [DATE] revealed resident had an onset of mental status change and had behavior of inattention and disorganized thinking that were continuously present. Active diagnoses included anxiety disorder, depression, bipolar disorder, psychotic disorder and Schizophrenia. The assessment also included that the resident was receiving on antipsychotic and antidepressant medications. A provider progress note dated September 8, 2025 revealed medical diagnoses that included Schizoaffective Disorder, Psychotic Disorder with Hallucinations Due to Known Physiological Condition, Bipolar Disorder, Current Episode Hypomanic, Depression, Anxiety Disorder, and Insomnia.A document signed by the administrator (staff #411) and dated September 16, 2025 revealed a handwritten note stating that the facility does not have PASARR Level II referral for resident #14. An interview was conducted on September 16, 2025 at 4:23 PM with a case manager (Staff #15) who stated that she primarily deals with the skilled side of the facility; and her responsibilities included conducting a UDA (User Define Assessment) and MDS in 3 days, advocating for the residents when they arrived at the facility, meeting weekly with IDT (Interdisciplinary Team) team for discharge plans, ordering DME (Durable Medical equipment), hospice, and handling complaint and grievances. The case manager stated that she was not trained and does not do PASRR screening but the resident relation manager (Staff #44) does. On September 16, 2025, at 4:29 PM, an interview was conducted with the Resident Relations Manager (CNA/Staff #44) who stated that a PASRR (Preadmission Screening and Resident Review) is completed upon admission, and she ensures that residents coming from the hospital have a PASRR in (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	place. She stated that a 30-day PASRR is completed for residents who remain in the facility for more than 30 days, and a Level II PASRR is completed when indicated-such as when a resident exhibits behaviors or is prescribed psychiatric medications. Staff #44 reported that she conducts the pre-screening portion of the PASRR process and then contacts the appropriate person to complete the Level II evaluation if needed. According to her, the evaluating psychiatrist will determine whether a resident requires a Level I or Level II PASRR and will contact her if a Level II is needed. During the interview, a review of Resident #14's clinical record was conducted with Staff #44 who said that the PASRR screening dated January 1, 2024, was completed by the transferring hospital; and, a second PASRR, dated January 29, 2024, was also completed by the hospital. She stated that both were Level I screenings. Further, she said that Resident #14 was readmitted to the facility on [DATE], and another Level I PASRR was completed on March 3, 2024, because the resident had remained in the facility for more than 30 days. Staff #44 noted that while the screening documented diagnoses of anxiety and depression, nothing was marked under Serious Mental Illness in Section B. However, Resident #14's clinical record includes diagnoses of schizoaffective disorder, bipolar disorder, and psychotic hallucinations. She stated that no Level II PASRR referral was made and said she could not explain why, as she was not in the position to handle PASRR screenings at that time. She stated that Resident #14 should have been assessed and referred for a Level II PASRR and confirmed that no additional PASRR screenings have been completed since March 3, 2024.Review of facility's policy titled, Pre-admission Screening and Resident Review (PASRR), revealed that if the resident is positive for potential MI (Mental Illness), a Level II PASRR referral must be submitted. It is the responsibility of the facility to make referrals for a Level II PASRR, or in some cases, to ensure the referral is made by the ALTCs case manager, if a Level II PASRR is determined to be necessary.

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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 observations, clinical record review, resident and staff interviews, and facility policy and procedure, the facility failed to coordinate with hospice to ensure quality care and services for one resident (#29). The deficient practice could result in residents not receiving the appropriate interventions for their comfort and end of life services.Findings include: A hospital record dated June 12, 2025 documented resident's plan of care included full liquid diet and continue supportive care. The plan indicated that the resident is to remain on full liquid diet indefinitely. Resident # 29 was admitted to the facility on [DATE] with diagnoses of malignant neoplasm of the pancreas, atherosclerotic heart disease, type 2 diabetes mellitus, and anxiety disorder. Review of the hospice respite care document dated August 29, 2025 revealed a diagnosis of malignant neoplasm of the pancreas. The paperwork indicated the resident's diet as as tolerated. A care plan revised on August 29, 2025 revealed that the resident was on hospice for terminal diagnosis of pancreatic cancer. Interventions included nutrition/hydration to maintain comfort. Review of the Order Summary Report revealed a physician order dated August 29 2025 which prescribed a regular diet with diabetic preference. The order indicated regular texture and thin liquids consistency. The 30-day (August 31, 2025 thru September 16, 2025) look back of the CNA (Certified Nursing Assistant) task log for eating revealed that during that timeframe, there were 15 instances of resident refusal, 10 instances in which resident only consumed 0-25% of his meal, 7 instances in which resident consumed 26-50% of his meal, 6 instances which resident consumed 51-75% of his meal, and only 2 instances that the resident consumed 76-100% of his meal. However, review of the 30-day look back of the CNA task log for snack offered revealed documentation for only 9 days out of the 30 days. The documentation indicated the following:- August 29, 2025: taken- August 30, 2025: taken- September 4, 2025: not applicable- September 5, 2025: not applicable- September 6, 2025: resident refused- September 11, 2025: taken- September 12, 2025: taken- September 13, 2025: taken- September 15, 2025 - two encounters: both marked as taken A Dietary Communication form dated September 1, 2025 revealed that the resident's diet was regular. The texture was marked as regular. Fluid was marked as thin. The hospice section was marked as tolerated. A revised care plan dated September 3, 2025 indicated that the resident was at risk for decreased/variable intakes. The goal was for the resident not to experience unsatisfied hunger or thirst. Interventions noted that resident prefers a pureed diet, liquified per resident preference, provide with food preferences, and encourage intake of food/fluids. However, review of the admission Nutrition Data Collection and Assessment dated September 3, 2025 revealed that the Food & Fluid Preference/Likes section documented see tray ticket. Additionally, the Nutritional Monitoring and Evaluation section indicated continue to monitor nutrition related concerns and give comfort care. Although, resident's intake was monitored via the CNA task log for eating and snacks offered, review of the clinical record did not reveal any indication that the issue with regards to poor intake or refusal to eat was relayed to hospice or that comfort care was provided in response to this issue. An admission Minimum Data Set (MDS) assessment date September 4, 2025 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating that the resident was cognitively intact. The assessment documented that the resident did not have dental or oral issues. Additionally, the MDS noted that the resident was receiving hospice care. A progress note dated September 4, 2025 documented that resident had nausea, abdominal pain, very poor appetite, and complained of difficulty or pain when swallowing mechanically altered diet. However, review of the resident's clinical record did not reveal any indication that hospice was notified of the situation or that the facility's provider was informed of the issues. A progress note dated September 6, 2025 documented that the resident did not consume anything that day other than water. According to the note, the resident preferred to sleep. The note also indicated that the resident complained of difficulty or pain when swallowing mechanically altered diet. Additionally, there was no evidence that the issues/concerns were (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Haven of Lakeside		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 North Lockwood Drive Lakeside, AZ 85929	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	addressed. However, review of the resident's clinical record did not reveal any indication that hospice was notified of the situation or that the facility's provider was informed. Additionally, there was no evidence that the issues/concerns were addressed. Furthermore, there was no evidence that the resident was on mechanically altered diet. Another progress note also dated September 6, 2025 documented that resident #29 had to be woken up several times throughout the date to ensure he was okay. According to the note the resident refused any meals and medications. However, further review of the resident's clinical record did not indicate any documentation that hospice was notified or that the facility's provider was informed of the situation. Additionally, there was no evidence that the issues/concerns were addressed. Review of the facility's Incident Report dated September 7, 2025 revealed that resident #29 sustained a fall resulting in a dime sized abrasion to the back of his head/top of scalp. The report did not indicate what time the incident took place. Per the report, the nursing staff witnessed the resident walking behind his wheelchair when he lost his balance and fell backwards hitting the top of his head. According to the Incident Report, hospice was notified regarding the fall on September 7, 2025 at 11:49 p.m. However, a progress note dated September 8, 2025 noted that resident #29 stated that the resident sustained a fall on September 7, 2025 at 10:40 p.m. The note indicated that the Director of Nursing (DON) was notified and that facility protocol was followed. The note did not specify if hospice was notified of the incident. Additionally, review of the IDT (Interdisciplinary Team) Fall Review document dated September 8, 2025 documented that notifications were made to providers and family and did not specify that hospice was included in the notification. A progress note pertaining to the IDT Fall Review dated September 8, 2025 documented that the resident sustained a fall with minor injury on September 7, 2025 at 11:00 p.m. The note indicated that Notifications were made to providers and family. But the note did not specify whether hospice was notified. A progress note dated September 12, 2025 documented that resident had very poor appetite and difficulty or pain when swallowing mechanically altered diet. However, further review of the resident's clinical record did not indicate any interventions to address the issue. Additionally, there was no evidence that the resident's poor appetite and difficulty/pain when swallowing was relayed to hospice. Furthermore, there was no evidence that the issues/concerns were addressed. An interview with a Licensed Practical Nurse (LPN/staff #43) was conducted on September 16, 2025 at 6:58 a.m. Staff #43 stated that resident #29 does not normally eat breakfast and has to be coached a lot. Per the LPN, the resident noted that he is often nauseated and had to be given his prescribed medication for nausea. Staff #43 said that breakfast is normally the only meal with issues. During an interview with staff #28 conducted on September 16, 2025 at 7:05 a.m., staff #28 said that resident #29 normally refuses food. According to staff #28 the resident refuses food because he does not like the food. Staff #28 relayed that resident #29 asked his case manager about getting food from a delivery service since he cannot eat the food. When the resident does eat, he consumes between 25-50% of his meals. Staff #28 said that yesterday, the resident asked for soup since he could not eat his food. An interview with resident #29 was conducted on September 16, 2025 at 7:09 a.m. Resident #29 stated that he does not eat the food because it is not consistent with his needs. According to resident #29 he has pancreatic cancer and needs soft food. However, most of the meals he receives is not soft. Resident #29 said that when he askes for something else, he is told that it would take hours. He said that sometimes he is able to get alternate meals but other times he just goes hungry. An observation of resident #29's breakfast tray was conducted on September 16, 2025 at 7:30 a.m. Resident #29's breakfast consisted of apple juice, a piece of toast sliced in half, 2 pieces of really crispy bacon, and scrambled eggs. In a follow-up interview with resident #29 conducted on September 16, 2025 at 7:32 a.m., the resident stated that this breakfast is too tough for him with his cancer. Resident #29's meal ticket for breakfast on September 16, 2025 was reviewed with staff #28 and revealed the following:- Regular diet, regular texture, thin liquid consistency; low carbohydrates preference- Dislikes section was left blank- Likes section was left blank- Beverage preference was left blank- Tray instructions was left blank- Assist instructions indicated to send (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	applesauce and pudding During the post-breakfast meal observation of resident #29's meal tray with staff #28 conducted on September 16, 2025 at 7:53 a.m., staff #28 stated that the resident consumed 15-20% of his meal. The resident appears to have eaten 1 of the 2 pieces of back, almost half of the toast, and some of the scrambled eggs. Review of resident #29's lunch meal ticket for September 16, 2025 revealed an alternate meal request of chicken soup or vegetable soup and hot dog with ketchup. During an interview with the Dietary Manager (staff #90) conducted on September 16, 2025 at 11:29 a.m., staff #90 stated that he has not heard about any issues with resident #29. The Dietary Manager said that there are no listed preferences for this resident and that his is on a regular/regular diet. According to staff #90, resident #29 has cancer so sometimes he does not eat but wants soup. The Dietary Manager stated that over time resident #29 has gotten sicker so they make him whatever he wants. In a follow-up interview with resident #29 conducted on September 16, 2025 at 12:54 p.m., he stated that the meal was not acceptable as it was hard to eat. Resident #29 noted that since he has cancer, he is only able to have liquids. During an observation of resident #29's lunch tray on September 16, 2025, a bag of chips was observed open and it appeared that the resident took a bite out of the hotdog. The resident was eating his soup. A telephonic interview with the hospice's Director of Clinical Services (DCS/staff #500) was conducted on September 16, 2025 at 2:03 p.m. Staff #500 stated that resident #29 originally admitted to the facility for respite care on August 29, 2025 and was supposed to discharge on [DATE]. However, the resident remained in the facility since he felt unsafe at home by himself. According to the DCS, the resident is deciding whether he would remain at the facility for long term care or discharge home. Staff #500 said that the resident is visited by a hospice nurse twice a week and as needed and a hospice aide, once a week or as needed. The last hospice visit was yesterday. Per the DCS, her expectation is that hospice is notified if a resident sustains a fall or has a change in condition or has issues/concerns. Staff #500 said that it is important that facility informs hospice of any changes so they can determine if the resident is experiencing further decline. Additionally, changes should be relayed to hospice so that hospice can determine if there are adjustments that can be made to address the decline/developing symptoms. The DCS noted that from a hospice standpoint information is used to ensure the residents are provided comfort and control symptoms. Staff #500 stated that to her knowledge and review of the resident # 29's hospice record in conjunction with this interview, the facility did not notify hospice that the resident sustained a fall or that the resident was having food intake issues. She indicated that those are information that should have been relayed to hospice. Review of the Order Summary Report revealed a physician order dated September 16, 2025 which prescribed regular with diabetic preferences. The order indicated pureed texture, thin liquids consistency and that per resident's request may liquify to resident preference. An interview with an LPN (staff #43) was conducted on September 16, 2025 at 5:18 p.m. Staff #43 stated that if a hospice resident sustained a fall, hospice would be contacted as part of the notification. This is also the case if a hospice resident's eating pattern changes or if the resident is having issues eating. According to the LPN, it is important to notify hospice so that everyone is aware of what is going on and determine the right treatment/intervention. Staff #43 stated that in the case of a hospice resident's change in eating habits, not addressing the issue could result in the resident feeling d and not depressed. The LPN noted that resident #29 had reported being nauseated but had not been informed of him experiencing hunger. During an interview with the Director of Nursing (DON/staff #80) conducted on September 17, 2025 at 8:34 a.m., staff #80 stated that his expectation with regards to falls is that staff follow the facility policy. This meant that resident is assessed and based on assessment that interventions are put in place. According to the DON the family and provider should be notified of the incident. Staff #80 noted that in the case of hospice residents, hospice should be notified rather than or along with the facility's provider. The DON stated that this is important so that appropriate interventions can be given for that resident's needs. Per staff #80 the potential impact of not notifying hospice depends. He explained that if the facility provider was notified then it would not impact the care. The DON said (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that if there was no attempt to contact the hospice then the impact would be situational. Although, staff #80 agreed that care for hospice residents is a collaboration between the facility and hospice, if there was no documentation on both sides that the issue was relayed to hospice, then the facility should look at what could have been done since it would be an individual problem. According to the DON although hospice is responsible for end of life care, the overall care is not affected if there is a facility provider that can provide appropriate interventions. With regards to nutrition/food intake issues, staff #80 said that his expectation is that staff members follow the facility policy which entails notifying the provider overseeing the care so that the resident can receive interventions. In the case of hospice residents, his expectation is that the resident's issue is still addressed the same way. However, per the DON it is not necessary for hospice to be involved as long as they receive direction from the facility physician. Staff #80 said that it is important to communicate/address nutrition/food intake issues so that they can collaborate to solve it and have interventions in place from provider. The DON noted that the impact can vary on nursing interventions. Review of the facility's hospice agreement revealed that the facility's responsibilities regarding notification indicated that the facility immediately notify hospice when: a significant change in the resident's physical, mental, social or emotional status occurs, clinical complications have appeared that suggest a need to alter the plan of care, a life-threatening condition appears, a need to transfer the resident from the facility arises, and if the resident dies. Further review of the facility's hospice agreement noted the joint responsibilities of both the facility and hospice included Development and Implementation of Care Plan noted that hospice shall retain overall professional management responsibility for directing the implementation of each resident's plan of care. Additionally, the Modification of Plan of Care portion of the agreement indicated that hospice and facility shall jointly coordinate and participate in periodic review and modification of the resident's plan of care, taking account any changes in the resident's conditions. Furthermore, the agreement directed that hospice and facility shall document the review and modification, and shall immediately notify the other party of any change in condition of a resident that requires a change in the resident's plan of care. Review of the facility policy titled End of Life Care: Hospice Program version 051123 and in effect January 1, 2024 indicated that it is the responsibility of the hospice to manage the resident's care as it related to the terminal illness and related conditions. Per the policy this includes changing the level of services provided when it is deemed appropriate and providing medical direction, nursing, and clinical management of the terminal illness. Additionally, the policy noted that it is the facility's responsibility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriately based on the resident's needs. Per the policy this includes notifying the hospice about significant change in the resident's physical, mental, social, or emotional status. Furthermore, the facility is responsible for communicating with the hospice provider and documenting such communication to ensure that the needs of the resident are addressed and met 24 hours per day. The facility policy titled Resident Nutrition Services version 2.1, revised November 2015 stated that significant variations from usual eating or intake patterns must be recorded in the resident's medical record. The Nurse Supervisor and/or Unit Manager shall evaluate the significance of such information and report it, as indicated, to the attending physician and dietitian. The policy noted that nursing personnel will evaluate food and fluid intake in residents with, or at risk for, significant nutritional problems. The policy indicated that nursing staff will assess and document the amounts eaten as indicated for individuals with, or at risk for, impaired nutrition. The policy stated that each resident shall receive meals, with preferences accommodated, prompt meal service and appropriate feeding assistance. Review of the facility policy titled Resident Safety: Accidents and Incidents - Investigating and Reporting version 051123 and in effect January 1, 2024 stated that the following data shall be included in the Report of Incident/Accident form the time the injured person's attending physician was notified, as well as the time the physician responded and his or her instructions. The facility policy titled Documentation: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Charting and Documentation version 051123 and in effect January 1, 2024 noted that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychological condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews and review of facility policies and procedure, the facility failed to ensure appropriate treatment and services was provided to 1 of 3 sampled residents (#22) with limited ROM.Findings include: Resident #22 was admitted on [DATE] with diagnoses of dementia, hemiplegia/hemiparesis following cerebral infarction, cerebral atherosclerosis, dysphagia, and dysarthria. The OT (occupational therapy) evaluation dated November 1, 2021 included that resident required skilled OT services to improve rehab potential, increase functional activity tolerance, increase independence with ADLs (activities of daily living) and increase safety awareness. Per the documentation, the resident presented with deficits in ADL performance, strength, functional mobility and cognition; and that, skilled OT services was required to maximize functional performance, address deficits and promote safe discharge. Musculoskeletal assessment included that ROM (range of motion) of both upper extremities were within normal limits. The PT (physical therapy) evaluation dated December 17, 2021 revealed that skilled PT was required to address functional deficits and underlying impairments for maximal functional independence. Treatment approaches included therapeutic exercises/activities, neuromuscular reeducation, gait training, manual therapy techniques, group therapeutic procedure, and wheelchair management training. Clinical Impressions included that the resident had functional deficits in bed mobility, transfers, gait with impaired neuromuscular control, balance, strength and endurance. Per the documentation, the resident had no equipment prior to CVA (cerebrovascular accident). The care plan dated February 6, 2024 included that the resident was dependent on staff for activities, cognitive stimulation and social interaction. Interventions included that all staff to converse while providing care, needed assistance with ADLs as required during the activity and needed assistance/escort activity functions. The therapy services screening dated October 23, 2024 revealed the resident reportedly coughing with chopped meals. The recommendation included all ground diet, with extra gravy/moisture. The documentation did not include any limitation in the resident's ROM. The late entry NP note dated May 19, 2025 included that the resident had weakness. The documentation did not include that the resident had any limitation with ROM of the upper extremities. The NP encounter notes dated May 21 and June 4, 2025 revealed that the resident had no gross musculoskeletal angulations or deformities. The IDT (interdisciplinary team) care conference dated June 12, 2025 revealed that resident needs were being met and there were no concerns. The NP encounter notes dated July 16 and July 20, 2025 included resident was alert and oriented x 0 and had no gross musculoskeletal angulations or deformities. The quarterly nursing summary dated July 29, 2025 included that the resident was oriented x3, had bowel and bladder incontinence and had manual wheelchair. The documentation did not include that the resident had any limitation with ROM of the upper extremities. The annual MDS assessment dated [DATE] included a BIMS (brief interview for mental status) score of 99 indicating severe cognitive impairment. Active diagnoses included aphasia, non-Alzheimer's dementia, hemiplegia/hemiparesis, dysphagia and cerebral atherosclerosis. The assessment did not code for therapy and/or recreational therapy; and, there were no RNA (restorative nursing assistance) and/or use of splint/brace coded. The late entry provider progress note dated August 8, 2025 revealed that the resident lived at the facility because of dementia, was alert and oriented x 0 and had right-sided weakness. Physical exam included generalized weakness. Problem lists included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphasia/dysarthria following cerebral infarction. The documentation did not included that the resident had any limitation with ROM of the upper extremities. The late entry physician progress note dated August 25, 2025 revealed that the resident was alert and oriented x 0 and had right-sided weakness. Physical exam included generalized weakness. Problem lists included hemiplegia and (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hemiparesis following cerebral infarction affecting right dominant side, dysphasia/dysarthria following cerebral infarction. The documentation did not included that the resident had any limitation with ROM of the upper extremities. The weekly assessment dated [DATE] revealed no skin issues. Further review of clinical record revealed that the resident was assessed for the extent and limitations of movement of his joints since the PT and OT evaluation in 2021. There was also no documentation the resident had previously received treatment and services for ROM and whether the resident's ROM was maintained or declined. The clinical record also revealed no documentation of a reason why ROM services was not provided to the resident; and that, the resident refused ROM services. There was also no evidence in the clinical record that the resident was a care plan was developed with interventions to address resident's limited ROM. During an observation conducted on September 14, 2025 at 12:07 p.m., resident #22 was sitting in his wheelchair and was eating his meal using his left hand. The resident's right wrist was bent in a downward direction towards the underside of the right forearm; and his right thumb and pointer finger were bent inwards towards the palm of the hand. The resident did not have any splint or brace in place on his right wrist and right hand. On September 14, 2025 at 1:40 p.m., resident #22 was using the side rails with his left hand to wheel himself from the nurse station down the hallway of the unit . His right wrist was bent in a downward direction and was in front of his abdominal area. His right thumb and pointer finger were bent inwards towards the palm of the hand; and, he does not have any any splint or brace in place on his right wrist and right hand. In another observation conducted on September 15, 2025 at 12:03 p.m., resident #22 sitting in his wheelchair in the dining room and eating his meal independently using his left hand. His right wrist was bent in a downward direction and was in front of his abdominal area. His right thumb and pointer finger were bent inwards towards the palm of the hand; and, he does not have any any splint or brace in place on his right wrist and right hand. An interview with a certified medical assistant (CMA/staff #39) was conducted on September 15, 2025 at 1:02 p.m. The CMA stated that resident #22 had a bad stroke and was admitted at the facility with weakness on the right side. She stated that resident #22 was currently not on therapy; and, the resident cannot move his right arm, cannot open/close his right hand and cannot move his fingers on the right hand. She stated that the right wrist, and fingers on the right hand were now stiff and hard. She stated that resident #22 was referred to therapy, had therapy initially but then the resident started refusing them. She stated that the resident were offered/given some splint devices in the past to help his hands open up but the resident refused to use them. She stated that resident #22 was not on any RNA program but, she attempted doing some exercise with his hands when providing cares but resident #22 would immediately take his arm from her. The CMA further stated that she was not aware that a therapy screen for further decline of ROM was completed for resident #22. During an interview with the Director or Nursing (DON/staff #80) conducted on September 17, 2025 at 8:34 a.m. the DON stated that when staff identified an issue related to resident care, the expectation was for staff assess the resident; and, based on the assessment, interventions are put in place and implemented. He also stated that his expectation was that staff members follow the facility policy which entails notifying the provider overseeing the care so that the resident can receive interventions; and, while waiting for the provider's order, nursing staff should discuss with each other if there are interventions that can be implemented in the mean time. The DON said that it was important to communicate/address issues identified so that they can collaborate to solve it and have interventions in place from provider. Further, the DON noted that the impact can vary on nursing interventions. In an interview with the director of rehabilitation conducted on September 17, 2025 at 9:00 a.m., the director stated that residents must be screened by therapists. The facility's policy on Restorative Nursing Services revealed resident w will receive restorative nursing care as needed to help promote optimal safety and independence. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e.g., physical, occupational or speech therapies. Restorative goals and objectives are individualized and resident-centered, and are outlined in the (continued on next page)

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	035277	A. Building B. Wing	11/19/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, staff interviews, review of facility documentations and policy, the facility failed to ensure that medications were secured and stored properly. The deficient practice could result in unauthorized access to medications and could place resident's safety at risk.Findings include:A medication administration observation was conducted with Licensed Practical Nurse (LPN/Staff #47) on September 15, 2025 at 11:19 AM. There was a gray basin covered with a white towel located on top of the medication cart. Staff #47 pulled a bottle of lactobacillus acidophilous (probiotic) from the gray basin then took one capsule from the bottle placed it in the medication cup and administered the medication to a resident. An interview was conducted with the LPN (Staff #47) on September 15, 2025 at 11:29 AM. Staff #47 stated that the gray basin which was covered with white towel and located on the top of the medication cart contained apple sauce, acidophilous (probiotic), and ensure (supplement). She stated that she keeps the bottle of lactobacillus acidophilous in the basin to keep it cold by using ice packs. She said that does not lock the lactobacillus acidophilous in the medication cart because she has to keep it on ice and that was why it was in a basin. She further stated that the basin was covered with a towel to keep the residents away and to keep it hidden because tempted eyes likes to touch things. During an observation of the medication room conducted with another LPN (staff #89) on September 15, 2025 at 11:43 AM, the LPN (staff #89) stated that the facility has one locked medication room. This room stores IV supplies such as flushes, tubing, syringes, and individualized labeled IV medication bags (not yet mixed), as well as lab supplies. She said that the room also contains a refrigerator for specimens, another refrigerator for medications like insulin pens, a locked box inside the refrigerator for medications requiring secure storage, and a freezer for ice packs. The LPN said that medications requiring room temperature storage, such as over-the-counter (OTC) medications, were stored either in the medication room or in the medication cart; and, medications requiring refrigeration were stored in the refrigerator. The LPN stated that for medications like Lactobacillus, which need to be kept cool, an ice bucket with an ice pack was used on the medication cart; and, ice packs were changed as they melt, which was why the freezer contains a large supply of them. She further stated that Lactobacillus, which was an OTC probiotic, was sometimes stored on top of the medication cart in a covered ice bucket (covered with a towel to keep it out of residents' view), and was not kept in locked storage; and that, this had been the standard practice at the facility. The LPN said that if Lactobacillus was not kept on ice or was placed inside a drawer without proper cooling, it does not meet storage standards; and, since it is a live culture, improper temperature can reduce its medicinal effectiveness. The LPN further stated that the preferred alternative would be to store it in the refrigerator and retrieve it as needed; and that, this was something staff may not have considered carefully before, and in hindsight, should have. Additionally, she emphasized that if a medication was not locked, there is a risk a resident could access it and take it without a physician's order.On September 15, 2025 at 1:45 PM an interview was conducted with LPN (Staff #89) with a Registered Nurse (RN/Staff #14) present. The LPN removed the white towel that covered the gray basin on the medication cart and pulled a bottle of Lactobacillus from the basin. The LPN stated that the bottle of Lactobacillus included a written instruction to store unopened bottle at room temperature; and, after opening to refrigerate the bottle. The LPN said that this was why the bottle was stored in the basin with ice pack.In an interview conducted on September 16, 2025, at 10:01 AM, the Director of Nursing (DON/Staff #80) who stated that the expectation during medication administration for all staff, including himself, was to follow facility policy, review the order, and follow the physician's instructions. The DON stated that medications were stored in the medication room for bulk storage and specific medications were stored in the cart. He said that supplements such as calorie supplement protein, med pass, protein (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Lakeside	3401 North Lockwood Drive Lakeside, AZ 85929

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shakes were stored outside the medication cart on ice and probiotics were stored on ice according to the manufacturer's direction. The DON stated that a probiotic is a supplement used to assist with microbiome in the GI (gastrointestinal) tract; and can be ordered by the dietician but probiotic is ultimately ordered by the doctor. The DON also stated that their medication carts and medication room were both locked following regulations and policy. He stated that he would consider a probiotic such as Lactobacillus as a supplement stored according to the manufacturer's direction but can be placed in the ice box on top of the medication cart and not locked. He stated that a probiotic supplement would be stored according to manufacturer's direction i.e., stored on ice after opening. he DON stated that he does not believe that there was any risk for the other residents other than spoilage if not following manufacturer's direction.A review of facility policy titled, G001-Orders/Receiving/Transcribing: Medication and Treatment Orders, effective date January 1, 2024 revealed orders for medications and treatments will be consistent with principles of safe and effective order writing.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on documentation, staff interviews, and facility policies the facility failed to ensure that two staff members (#21, and #58) are educated on infection control and prevention. The deficient practice could result in staff not being familiar with process and procedures for the control and prevention of infection. Findings include:-Regarding Staff #21Review of the personnel record for a Registered Nurse (RN/staff #21) revealed a hire date of August 1, 2024. Additionally, the personnel file revealed a signed job description dated August 4, 2024 that outlined tasks and responsibilities which stated that staff will participate in all required meetings, trainings and events. The file also included a New Employee Orientation Acknowledgement signed August 4, 2025. However, it did not indicate what training were covered under this orientation. Further review of the personnel file provided by the facility did not reveal any evidence that staff #21 completed Infection Control training. Review of the Inservice training log/binder conducted on September 15, 2025 at 4:03 p.m. did not reveal any evidence that staff #58 completed Infection Control training. During a sit down with Human Resource (HR/staff #70) conducted on September 16, 2025 at 9:47 a.m., staff #70 along with the surveyor verified on the training system that Infection Control training was not assigned or completed by staff #21. HR noted that he would have to call the training system resource to add courses/loaded. However, review of an email sent by the facility after the survey exit, received September 17, 2025 at 2:09 p.m. noted that all staff sampled had completed training. An attachment marked Clinical Staff Annual Education with a handwritten start date of June 15, 2025 and finished date of July 15, 2025 indicated that Abuse and Elder Justice Act were topics covered. The training included a typed roster with a list of the staff and a training complete section. The roster included staff #21's typed name and on the training complete section a handwritten check mark was annotated. There was no clear indication of when staff #21 and the other staff on the roster actually completed the training. -Regarding Staff #58Review of the personnel record for a Licensed Practical Nurse (LPN/staff #58) revealed a hire date of September 20, 2016. Further review of the personnel file provided by the facility did not reveal any evidence that staff #58 completed Infection Control training. The personnel file revealed a signed job description dated September 20, 2016 that outlined tasks and responsibilities which stated that staff will participate in all required meetings, trainings and events. During a sit down with Human Resource (HR/staff #70) conducted on September 16, 2025 at 9:47 a.m., staff #70 along with the surveyor verified on the training system that Infection Control training was not assigned or completed by staff #58. HR noted that he would have to call the training system resource to add courses/loaded. However, an email sent by the facility after the survey exit, received September 17, 2025 at 2:09 p.m. noted that all staff sampled had completed training. An attachment marked Clinical Staff Annual Education with a handwritten start date of June 15, 2025 and finished date of July 15, 2025 indicated that Elder Justice Act was among the topics covered. The training included a typed roster with a list of the staff and a training complete section. The roster included staff #58's typed name and on the training complete section a handwritten check mark was annotated. There was no clear indication of when staff #58 and the other staff on the roster actually completed the training. An interview with a Licensed Practical Nurse (LPN/staff #43) was conducted on September 16, 2025 at 5:18 p.m. Staff #43 stated that staff members are provider training via monthly in-service and yearly computer-based training. According to the LPN training is important for topics such as Infection Control so that staff do not spread infections and residents and other staff. The impact of not getting the appropriate training is that staff would not know what to do if a situation arises or how to take care of the resident. During an interview with a Certified Nursing Assistant (CNA/staff #60) conducted on September 17, 2025 at approximately 8:30 a.m., staff #60 noted being a relatively new employee at the facility. According to the CNA, although on-the-job training was provided, training on Infection Control was not provided. Additionally, staff #60 was told (continued on next page)

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that there would be a series of online training that would need to be completed within 2-months. Staff #60 said that training is important for everyone's safety. The CNA noted that if staff is not provided appropriate training then they would not know how to react and would have to rely on common sense. An interview with the Director of Nursing (DON/staff #80) was conducted on September 17, 2025 at 8:34 p.m. Staff #80 stated that his expectation is that staff follow the facility policy with regards to training. This means completing the onboarding process for general orientation which covers the general education to start the job and do education periodically throughout the year. According to the DON it is important to have Infection Control training in order to have good resident outcomes. Staff #80 said that not having training could lead to a knowledge deficit which could lead to delayed responses and impact care. The facility policy titled Staff Development Program version 0123 stated that all personnel must participate in initial orientation and regularly scheduled in-service training classes. The policy noted that Infection Control was a state agency mandatory topic. Review of the Facility Assessment updated September 15, 2025 indicated that the facility's staff/training/education and competencies included Infection Control. According to the facility assessment competencies are started during orientation and had to be completed during the first few weeks of hire and then annually. The facility policy titled Infection Control Program version 0214 stated that all facility staff will be educated on hand hygiene, infection control, and isolation precautions on hire and annually. The policy noted that education may also be required on an ad hoc basis as deemed appropriate by the Infection Control Coordinator.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on documentation, staff interviews, and facility policies the facility failed to ensure that five staff members (#21, #58, #1, #55 & #11) received Dementia Care training. The deficient practice could result in staff not being familiar with process and procedures to care for residents with dementia.Findings include:On September 15, 2025 at 9:11 a.m., a written request for personnel files which included staffs #21, #58, #24, #1, #55 & #11) was submitted specifically asking for proof of training for Dementia Care. -Regarding Staff #21Review of the personnel record for a Registered Nurse (RN/staff #21) revealed a hire date of August 1, 2024. Additionally, the personnel file revealed a signed job description dated August 4, 2024 that outlined tasks and responsibilities which stated that staff will participate in all required meetings, trainings and events. The file also included a New Employee Orientation Acknowledgement signed August 4, 2025. However, it did not indicate what training were covered under this orientation. Further review of the personnel file provided by the facility did not reveal any evidence that staff #21 completed Dementia Care training. Review of the Inservice training log/binder conducted on September 15, 2025 at 4:03 p.m. did not reveal any evidence that staff #21 completed Dementia Care training. Furthermore, during a sit down with Human Resource (HR/staff #70) conducted on September 16, 2025 at 9:47 a.m., staff #70 along with the surveyor verified on the training system that Dementia Care training was not assigned or completed by staff #21. HR noted that he would have to call the training system resource to add course/get course loaded. However, an email sent by the facility after the survey exit, received September 17, 2025 at 2:09 p.m. noted that all staff sampled had completed training. An attachment marked Clinical Staff Annual Education with a handwritten start date of June 15, 2025 and finished date of July 15, 2025 indicated that Dementia and Managing Behaviors to Prevent Abuse was a topic covered. The training included a typed roster with a list of the staff and a training complete section. The roster included staff #21's typed name and on the training complete section a handwritten check mark was annotated. There was no clear indication of when staff #21 and the other staff on the roster actually completed the training. -Regarding Staff #58Review of the personnel record for a Licensed Practical Nurse (LPN/staff #58) revealed a hire date of September 20, 2016. Further review of the personnel file provided by the facility did not reveal any evidence that staff #58 completed Dementia Care training. Furthermore, the personnel file revealed a signed job description dated September 20, 2016 that outlined tasks and responsibilities which stated that staff will participate in all required meetings, trainings and events. An interview with Human Resource (HR/staff #70) conducted on September 15, 2025 at 2:04 p.m. Staff #70 stated that the training system itself is the one that assigns the courses. However, based on the personnel records that was reviewed together with the surveyor, he would need to find out why courses are not being assigned. According to HR the expectation is that assigned training is completed a month from when it is assigned. Review of the Inservice training log/binder conducted on September 15, 2025 at 4:03 p.m. did not reveal any evidence that staff #58 completed Dementia Care training. During a sit down with HR conducted on September 16, 2025 at 9:47 a.m., staff #70 along with the surveyor verified on the training system that the Dementia Management training was assigned staff #58. However, the training had not been completed. However, an email sent by the facility after the survey exit, received September 17, 2025 at 2:09 p.m. noted that all staff sampled had completed training. An attachment marked Clinical Staff Annual Education with a handwritten start date of June 15, 2025 and finished date of July 15, 2025 indicated that Dementia and Managing Behaviors to Prevent Abuse was among the topics covered. The training included a typed roster with a list of the staff and a training complete section. The roster included staff #58's typed name and on the training complete section a handwritten check mark was annotated. There was no clear indication of when staff #58 and the other staff on the roster actually completed the training. -Regarding Staff #1Review of the personnel record for a Certified Nursing (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistant (staff #1) revealed a hire date of February 28, 2025. The file also included a New Employee Orientation Acknowledgement signed February 28,2025. However, it did not indicate what training were covered under this orientation. Additionally, the personnel file revealed a signed job description signed on April 4, 2025 that outlined roles and responsibilities which stated that staff will participate in all required meetings, trainings and events. Further review of the personnel file provided by the facility did not reveal any evidence that staff #1 completed Dementia Care training. During the review of the training system with staff #70 for staff #1's training completion conducted on September 15, 2025 at 2:04 p.m., he noted that there is no documentation of Dementia Care training on either the training system or orientation. An interview with Human Resource (HR/staff #70) conducted on September 15, 2025 at 2:04 p.m. Staff #70 stated that the training system itself is the one that assigns the courses. However, based on the personnel records that was reviewed together with the surveyor, he would need to find out why courses are not being assigned. According to HR the expectation is that assigned training is completed a month from when it is assigned. Staff #70 recommended to check Inservice training log/binder to determine if staff # 1 completed Dementia Care training since it was not on the training system or the orientation training. Review of the Inservice training log/binder conducted on September 15, 2025 at 4:03 p.m. did not reveal any evidence that staff #1 completed Dementia Care training. Furthermore, during a sit down with Human Resource (HR/staff #70) conducted on September 16, 2025 at 9:47 a.m., staff #70 along with the surveyor verified on the training system that staff #1 had no documented Dementia Care training. HR noted that he would have to call the training system resource to add the course. Review of the email sent by the facility after the survey exit, received September 17, 2025 at 2:09 p.m. noted that all staff sampled had completed training. The following attachments were reviewed:- In-Service roster dated September 26, 2024 = did not include staff #1's name/was prior to hire date- In-Service roster dated May 20, 2025 = did not include staff #1's name- Clinical Staff Annual Education roster (June 15, 2025 - July 15, 2025) = typed name and handwritten check mark was annotated with no clear indication of when staff member actually completed the training -Regarding Staff #55Review of the staff list for a Licensed Practical Nurse (LPN/staff #55) revealed a hire date of February 5, 2019. Additionally, the personnel file revealed a signed job description dated February 12, 2025 that outlined tasks and responsibilities which stated that staff will participate in all required meetings, trainings and events. The file also included a New Employee Orientation Acknowledgement signed February 12, 2025. However, it did not indicate what training were covered under this orientation. Review of the personnel file provided by the facility did not reveal any evidence that staff #55 completed Dementia Care training. Furthermore, during a sit down with the Human Resource (HR/staff #70) to conduct personnel record review specific to training, conducted on September 15, 2025 at 2:04 p.m., staff #70 stated that staff #55 does not have documented training on either the training system or orientation for Dementia Care. HR recommended to check the Inservice binder to determine if staff #55 had completed the training. Review of the Inservice training log/binder conducted on September 15, 2025 at 4:03 p.m., did not reveal any evidence that staff #55 had completed Dementia Care training. Furthermore, during a follow-up sit down with Human Resource (HR/staff #70) conducted on September 16, 2025 at 9:47 a.m., staff #70 along with the surveyor verified on the training system that staff #55 had no documented Dementia Care training. HR noted that he would have to call the training system resource to add course/get training loaded. However, review of the email sent by the facility after the survey exit, received September 17, 2025 at 2:09 p.m. noted that all staff sampled had completed training. The following attachments were reviewed:- In-Service roster dated September 26, 2024 = did not include staff #55's name/was prior to hire date- In-Service roster dated May 20, 2025 = did not include staff #55's name- Clinical Staff Annual Education roster (June 15, 2025 - July 15, 2025) = typed name and handwritten check mark was annotated with no clear indication of when staff member actually completed the training -Regarding Staff #11Review of the personnel record for a Registered Nurse (RN/staff #11) revealed a hire date of February 17, 2025. Additionally, the personnel (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	file revealed a signed job description dated February 18, 2025 that outlined tasks and responsibilities which stated that staff will participate in all required meetings, trainings and events. The file also included a New Employee Orientation Acknowledgement signed February 18, 2025. However, it did not indicate what training were covered under this orientation. Review of the personnel file provided by the facility did not reveal any evidence that staff #11 completed Dementia Care training. Furthermore, during a sit down with the Human Resource (HR/staff #70) to conduct personnel record review specific to training, conducted on September 15, 2025 at 2:04 p.m., staff #70 stated that staff #11 does not have documented training on either the training system or orientation for Dementia Care. HR recommended to check the Inservice binder to determine if staff #11 had completed the training. Review of the Inservice training log/binder conducted on September 15, 2025 at 4:03 p.m., did not reveal any evidence that staff #11 had completed Dementia Care training. During a follow-up sit down with Human Resource (HR/staff #70) conducted on September 16, 2025 at 9:47 a.m., staff #70 along with the surveyor verified on the training system that staff #11 had no documented Dementia Care training. HR noted that he would have to call the training system resource to add courses/get training loaded. However, review of the email sent by the facility after the survey exit, received September 17, 2025 at 2:09 p.m. noted that all staff sampled had completed training. The following attachments were reviewed:- In-Service roster dated September 26, 2024 = did not include staff #11's name/was prior to hire date- In-Service roster dated May 20, 2025 = did not include staff #11's name- Clinical Staff Annual Education roster (June 15, 2025 - July 15, 2025) = typed name and handwritten check mark was annotated with no clear indication of when staff member actually completed the training An interview with a Licensed Practical Nurse (LPN/staff #43) was conducted on September 16, 2025 at 5:18 p.m. Staff #43 stated that staff members are provider training via monthly in-service and yearly computer-based training. According to the LPN training is important for topics such as Dementia Care so that staff would know how to handle and treat residents with dementia the right way. The impact of not getting the appropriate training is that staff would not know what to do if a situation arises. During an interview with a Certified Nursing Assistant (CNA/staff #60) conducted on September 17, 2025 at approximately 8:30 a.m., staff #60 noted being a relatively new employee at the facility. According to the CNA, although on-the-job training was provided, training on Dementia Care was not provided. Additionally, staff #60 was told that there would be a series of online training that would need to be completed within 2-months. Staff #60 said that training is important for everyone's safety. The CNA noted that if staff is not provided appropriate training then they would not know how to react and would have to rely on common sense. An interview with the Director of Nursing (DON/staff #80) was conducted on September 17, 2025 at 8:34 p.m. Staff #80 stated that his expectation is that staff follow the facility policy with regards to training. This means completing the onboarding process for general orientation which covers the general education to start the job and do education periodically throughout the year. According to the DON it is important to have Dementia Care in order for staff to be trained how to care for residents with dementia. Staff #80 said that not having training could lead to a knowledge deficit which could lead to delayed responses and impact care. The facility policy titled Staff Development Program version 0123 stated that all personnel must participate in initial orientation and regularly scheduled in-service training classes. The policy did not mention anything regarding Dementia Care training. Review of the Facility Assessment updated September 15, 2025 indicated that the facility's staff/training/education and competencies included Dementia training. According to the facility assessment competencies are started during orientation and had to be completed during the first few weeks of hire and then annually.